REPORT OF THE SUBCOMMITTEE ON INSTITUTIONAL PROGRAM GUIDELINES

Guidelines for Establishing Standards:

HEALTH CARE RELATED TO ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE

Health Services Directorate
Health Services and Promotion Branch

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■ NOTE

The information contained in these guidelines is considered current as of the date of their approval (1989); however, since many aspects of health care and health technology are constantly changing, any suggested amendments would be welcomed. Information on new developments or related issues should be directed to:

The Secretariat
Subcommittee on Institutional Program Guidelines
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
Ottawa, Ontario
K1A 1B4

Further copies of these guidelines, in English or French, can be obtained from the above address.

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■ PREFACE

The guidelines that follow on "Health Care Related to Abuse, Assault, Neglect and Family Violence, 1989" are one of a series of publications produced under the direction of the Subcommittee on Institutional Program Guidelines. Publications[1] *in this series provide a consistent definition of requirements for planning and administering a wide range of special services and programs in health institutions.*

In general, guidelines are based on information, knowledge, experience, research and expert opinion from health professionals and organizations throughout Canada. Additional material is often obtained from national and international health organizations, and from other experts knowledgeable in the subject. In this way many Canadians from across the country can contribute to the guidelines, and a consensus on the suggested approach can be achieved.

BACKGROUND

Under the direction of the Federal/Provincial Advisory Committee on Institutional and Medical Services, the guidelines program has been in operation since 1972. A standing subcommittee of the Advisory Committee, the Subcommittee on Institutional Program Guidelines, composed of federal and provincial government and professional representatives, coordinates the development of the guidelines commissioned by the Advisory Committee.

The guidelines are produced by expert working groups of health professionals, some of whom are government representatives. The final draft is reviewed and recommended by the Subcommittee, for approval by the Advisory Committee.

1 See Appendix IV, p. 98, LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

PURPOSE

The purpose of these guidelines is to provide a comprehensive definition of requirements for services in health institutions. While a consensus of expert knowledge and experience is reflected in the guidelines, such guidelines should not be regarded as rigid standards, particularly with respect to services experiencing rapid change. Provincial health authorities may modify the application of the guidelines to meet their needs.

Where development of a service is being contemplated, the guidelines may help in determining the need for such a service either locally or regionally, or in some cases provincially or interprovincially.

Established services may take advantage of the guidelines in screening deficiencies and solving problems without the need to develop new services. Where a service already exists the guidelines will help to

- identify problems related to administration, personnel, equipment and facilities
- determine necessary remedial action, and
- set priorities for corrective measures on the basis of clinical need, funding and the degree to which the service is deficient.

FUTURE

The dramatic increase in the number of intensive and special-care services in health institutions has given rise to the need for additional facilities, specialized equipment and highly trained personnel. At the same time, new approaches to patient care have evolved in a manner that emphasizes the need for a continuum of care, in which admission to an institution is only one aspect of total care. Therefore, linkages along the health-care continuum, ranging from illness prevention to chronic care, must be identified. As new treatments and procedures are put into practice, there will be a continuing need for guidelines to assist those involved in the planning and operation of services.

REVISIONS

Due to the rapidly changing nature of health-care delivery, guidelines will need updating and revisions. The Subcommittee on Institutional Program Guidelines plans and oversees these revisions.

GENERAL ACKNOWLEDGEMENTS

The Subcommittee acknowledges, with sincere appreciation, the immense amount of work undertaken and time given by practising Canadian health professionals and by others who in any way contributed advice and information to this endeavour.

■ LIST OF PARTICIPANTS

1. SUBCOMMITTEE ON INSTITUTIONAL PROGRAM GUIDELINES

The membership of the Subcommittee on Institutional Program Guidelines, responsible for the preparation of the new and updated guidelines, is as follows:

Donald F. Moffatt, Chairperson
Director
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Murray Barber
Programming Consultant
Design for Health Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Primrose Bishop
Director
Hospital Services Division
Department of Health
ST. JOHN'S, Newfoundland

Pauline F. Chartrand, Coordinator
Consultant, Long-Term Care
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Marcus Hollander
Program and Management Analysis
Continuing Care Division
Ministry of Health
VICTORIA, British Columbia

Dr. Gordon A. Judge
Medical Director and Associate Executive Director
St. Joseph's Hospital
HAMILTON, Ontario

M.H. (Scotty) Lamb
Director
Hospital and Medical Care
Institutional Operations Branch
Alberta Hospital and Medical Care
EDMONTON, Alberta

Phyllis MacDonald
Nursing Consultant
Urban Health Facilities Division
Manitoba Health Services Commission
WINNIPEG, Manitoba

David L. Martin
Consultant, Health Technology
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

André Nolet
Consultant, Health Administration
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Dr. Robert Seaver
Senior Medical Consultant
Institutional Division
Institutional Operations Branch
Ministry of Health
TORONTO, Ontario

2. WORKING GROUP ON ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE

The Guidelines for "Health Care Related to Abuse, Assault, Neglect and Family Violence" were prepared by a Working Group composed of a Steering Committee with Task Groups in the following areas: Child Abuse; Spousal Abuse; Sexual Assault; and Abuse of the Elderly, Frail or Vulnerable Adult. Additional materials were prepared on the interface between health and community services, and on medicolegal issues.

The Steering Committee included experts from the fields of medicine, including emergency, family and forensic medicine; administration; nursing, including emergency nursing; and social work, including medical and community social work. Task Groups, usually regional in nature, represented an interdisciplinary team of Working Group members, either formally or through their accumulated working experiences in interdisciplinary programs.

Steering Committee

Dr. Leonard A. Hargot, Chairperson of Working Group
Emergency Physician
Chedoke-McMaster Hospitals
Associate Professor
Department of Family Practice
Division of Emergency Medicine
McMaster University
HAMILTON, Ontario

Pauline Chartrand
(Project Coordinator: Dec.87-Jul.88)
Consultant, Long-Term Care
Institutional and Professional Services Division
Health Services Directorate
Health Services and Promotion Branch
Department of National Health and Welfare
OTTAWA, Ontario

Carol Clemenhagen
Also Co-convener: Spousal Abuse and liaison to
National Organizations
Vice-President, Representation
Canadian Hospital Association
OTTAWA, Ontario

Dr. Fionnella S.S. Crombie
Also Convener: Sexual Assault
(Initially Director, the Sexual Assault
Assessment Services, Halifax Infirmary
Assistant Professor
Department of Family Medicine
McMaster University
HAMILTON, Ontario

Dr. James A.J. Ferris
Also Convener: Medicolegal
Professor of Forensic Pathology
University of British Columbia
VANCOUVER, British Columbia

Susan Gilman, Project Resource Consultant
(Initially, from the National Clearinghouse
on Family Violence, National Health & Welfare)
Canadian Council of Children & Youth
OTTAWA, Ontario

Dr. Gordon A. Judge
Medical Director and Associate Executive Director
St. Joseph's Hospital
HAMILTON, Ontario

Nicole Latulippe
Also Convener: Elder Abuse
Acting Director General
Centre d'acceuil de Gatineau
GATINEAU (Québec)

Margaret MacDonald
Also Contributor: Elder Abuse
Consultant
Department of Health
Confederation Building
ST. JOHN'S, Newfoundland

Mary McKittrick, Project Coordinator
Consultant, Health Systems Research
Institutional and Professional Services Division
Health Services Directorate
Health Service and Promotion Branch
National Health and Welfare
OTTAWA, Ontario

Dr. Marcie Mian
Also Convener: Child Abuse
Director, SCAN Program
Hospital for Sick Children
TORONTO, Ontario

Lois Scott
Also Co-convener: Spousal Abuse
Emergency Department
The Moncton Hospital
MONCTON, New Brunswick

Mish Vadasz
Also Convener: Social & Community Services
Social Work Consultant
VANCOUVER, British Columbia

Task Group Members

Cheryl Barker
Contributor: Sexual Assault
Hants Community Hospital
HANTS COUNTY, Nova Scotia

Dr. Joyce Curtis
Contributor: Sexual Assault, and Alternate on Steering Committee
University Health Services
Dalhousie University
HALIFAX, Nova Scotia

Dr. Jean E. Drouin
Contributor: Elder Abuse
Medical Staff
Centre d'Acceuil de Gatineau
GATINEAU (Québec)

Lisette Hay-Paquin
Contributor: Elder Abuse
Nurse consultant
Centre d'Acceuil Foyer du Bonheur
HULL (Québec)

Dr. Carol Herbert
Contributor: Child Abuse
Family Practice
Faculty of Medicine
University of British Columbia
VANCOUVER, British Columbia

Renée Marcil
Contributor: Elder Abuse
Research Officer, Education
CHELSEA (Québec)

Maurice Miron
Contributor: Elder Abuse
Senior Consultant
Family Violence Prevention Division
Social Services Programs Branch
Department of National Health and Welfare
OTTAWA, Ontario

Barry Moore
Contributor: Sexual Assault
ARICHAT, Nova Scotia

Carol Wackett
Service for Sexual Assault Victims
HALIFAX, Nova Scotia

3. SPECIAL ACKNOWLEDGEMENTS

The Subcommittee is indebted to the general support and guidance provided by the Family Violence Prevention Division of the Department of National Health and Welfare and the Health Services and Promotion Branch liaison, Kathy Stewart. Partial funding for this project was provided through the Mental Health Division from the federal Child Sexual Abuse Initiative.

In preparing these Guidelines, the Working Group maintained liaison with the national organizations involved in the "Interdisciplinary Project on Domestic Violence":

Canadian Association of Chiefs of Police
Canadian Bar Association
Canadian Hospital Association
Canadian Medical Association
Canadian Nurses Association
The Church Council on Justice and Corrections
Canadian Institute on Child Health
Canadian Teachers' Federation
Canadian Association of Social Workers
Canadian Psychological Association

Review comments received from these organizations have been incorporated into the text. (The Phase I Report on this Interdisciplinary Project, entitled "The Other Side of the Mountain," is available from the National Clearinghouse on Family Violence, National Health and Welfare.)

In addition to the general review comments received from across the country, a number of experts have reviewed this document in some considerable detail and have provided comments that substantially strengthened the text. These include: Frankie O'Flaherty, Waterford Hospital, St. John's, Newfoundland; Jeanette Bartlett,

Seniors Secretariat, the Department of National Health and Welfare; and Femmy Mes and Barbara Merriam, Family Violence Prevention Division, National Health and Welfare.

INTRODUCTION

1. THE ROLE OF HEALTH FACILITIES IN ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE

These guidelines are directed to the specific responses of health institutions in meeting the needs of those involved in abuse, assault, neglect and family violence, and to the related medicolegal and forensic responsibilities. The particular areas covered are: child abuse, including sexual abuse and assault; spousal abuse, which is predominantly wife abuse; sexual assault, which is predominantly sexual assault of women; and abuse of the elderly, frail or vulnerable adult. These areas are presented as separate stand-alone sections of this guidelines publication. As a result, there may be some repetition of subject matter. The terms are defined separately in each section as their usage varies, depending on the type of abuse.

Since provincial legislation and program requirements vary from province to province, all programs related to issues of family and interpersonal violence must be developed in consultation with the appropriate provincial and local authorities. Community awareness and understanding of interpersonal and family violence is increasing, and this is reflected in rapidly changing legislative requirements, particularly with respect to reporting abuse. Planners and providers of health care must therefore keep abreast of current provincial legislative requirements and reporting mechanisms.

This document does not attempt to spell out professional roles, standards of professional practice or specific protocols. It is intended to provide guidelines for the development of programs and present the initial structural components necessary to initiate them.

Overview

Interpersonal and family violence are major social problems that originate from a broad spectrum of interrelated personal, social and behavioural factors, discussed in more detail on pages 5 to 8. As violence seldom originates from purely medical factors, there is no truly medical treatment or cure.

Promotion of healthy interpersonal relations; the prevention of serious sequelae to an initial abusive situation; screening, identification and protective intervention; assessment, planning and coordination; treatment and follow-up with identified victims and abusers: all these events can, and frequently do, take place without the involvement of health services.

Nevertheless, many violent situations come to the attention of health facilities for a variety of reasons. The most frequent is the injury or harm to the victim, and the necessity of treatment. Injuries may require emergency attention or other immediate medical, surgical or emotional intervention. Victims or abusers may come to hospitals for health concerns not directly or apparently related to their abusive situation. Health problems may be due to an immediate crisis, or the result of prolonged stress and victimization. Other victims of abuse may disclose the abuse or victimization while being treated for apparently unrelated problems.

Violence takes a heavy toll on the health and well-being of victim and abuser, both of whom frequently find their way to health facilities. Often they are fearful of disclosing their problems, and may deny them. Frequently, they are totally unaware of the help and intervention services that may be available.

Other reasons for the frequent involvement of health facilities in situations of violence and abuse are the need for carefully documented forensic evidence, and the security of institutions in particular as places of refuge. There is also an assumption that health facilities can intervene with greater autonomy and security than, for instance, a neighbour or a community resource. In addition, credibility and authority are traditionally attributed to the health professions by our society and our courts.

Health facilities thus find themselves in complex situations with complex roles with respect to family and interpersonal violence. These roles often require protective interventions and coordination not routinely or universally required of most health disciplines until recently. The special skills required have not yet been sufficiently incorporated into the education and preparation of health professionals.

Objectives

Health facilities, as major social organizations in our communities, must take a strong and visible position of opposition to violence in our society. Such a statement of philosophy should be

endorsed by governing boards and should be accompanied by a commitment to provide appropriate service to all concerned, through direct service or through community or regional networks of shared services on a planned basis. Boards are well-positioned to ensure that appropriate programs, procedures and protocols are designed, in accordance with provincial requirements and community expectations and needs.

Program Planning

Each health facility needs to assess its own program needs related to the following areas of concern:

- child abuse, including sexual abuse and assault of children
- spousal abuse
- sexual assault, and
- abuse of the elderly, frail or vulnerable adult.

These four general areas of concern are considered in detail in separate sections. Most health facilities need to develop programs, policies and procedures in all four areas. It is important to note that, regardless of the type or focus of the abuse, all members of the family constellation must be considered in approaches to program planning.

Administration and staff who do not see incidents of domestic violence in their jurisdictions will need in-service training in sensitization and identification of abuse. In an emergency department, recognition of family violence as the underlying or precipitating cause of injury or medical problems can increase ten-fold, once staff are trained to recognize and intervene appropriately.[2] Institutions without specialized pediatric departments, for example, may need to intervene to protect children in situations of family violence seen in other departments.

Facilities, such as children's hospitals and long-term care facilities, may require programs to address only some of these four major areas of concern. However, before limiting program goals, administrators, governing boards and senior staff will want to consult with an interdisciplinary cross-section of regional health and community planning organizations. Careful thought should be given to the

2 "New program to identify abuse first of its kind in Ontario", *Ontario Hospitals Today*, September, 1988, p.1. For further information contact the Social Work Department, Ottawa General Hospital.

overall needs of the patient group, the community, and the hospital's own employees who themselves are not immune from the toll of family violence.

Insights from the discussion that follows on pages 5 to 8 on UNDERSTANDING ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE may be helpful in considering which components to include in the profile for any particular program.

Levels of Service

Having determined which program components are appropriate, the next step in planning is to determine the level of service appropriate to each component. Again, these decisions should be made after consultation with the governing board, relevant senior staff, and provincial health authorities as well as regional health and community services planning bodies.

Levels of service will vary according to factors such as the size and role of the health facility, the availability of the requisite specialty expertise and accessibility of other designated community resources.

Levels of service for consideration include:

- identification and referral (basic to all programs)
- case assessment and/or consultation service, and
- treatment and case management.

Often the size of the community itself becomes a factor in selecting an appropriate level of service for any particular instance of family violence. In smaller communities, both victim and abuser sometimes prefer referral to an outside resource for reasons of security or confidentiality.

Suggestions for regionalization of responsibility and methods for accessing various community services for cooperative assistance in meeting these responsibilities are included in each section. Consideration should be given to the advantages of shared services to meet these responsibilities.

Victim support and advocacy groups should be considered whenever possible at appropriate stages of intervention.

Some general checklists for program planning, applicable to all four areas of concern, are also included as appendices on pages 91 to 97. These appendices, which are intended as general guides only and must be adapted to each specific program, include:

APPENDIX I. POLICIES AND PROCEDURES CHECKLIST
APPENDIX II. CHECKLIST FOR CARE AUDITS
APPENDIX III. SUGGESTED ROLES FOR STAFF

Whatever the level of service, a facility must define and implement objectives, policies and procedures, protocols, in-service training and services based on compassionate and perceptive understanding of the nature and indications of victimization.

2. UNDERSTANDING ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE[3]

In our society, the 20th Century has seen a dramatic change in attitudes to abuse, assault, neglect and family violence. This evolving social sensitivity to the enormous physical, emotional and economic costs of victimization compels the allocation of resources — both human and physical — in efforts to prevent, identify, intervene and manage this problem. Health facilities and staff occupy a pivotal role in these endeavours.

Separate Beginnings

Structures for responding to patterns of victimization are not entirely new in our society. Contemporary perceptions and understanding of these social problems, however, have changed both the nature and the public expectations of these interventions.

Since recognition of the "battered child syndrome" some 30 years ago, health professionals — both clinicians and researchers — have embraced the issue of child abuse within the context of medical diagnosis and treatment. Perceptions of wife assault and sexual assault have assumed new meanings in response to grass-roots or community-based initiatives, particularly as a result of the growing social concerns of women as equally valuable members of our

[3] This section is based substantially on the article by David Finkelhor, "Common Features of Family Abuse", in *The Dark Side of Families*, ed. by David Finkelhor, Richard J. Gelles, Gerald T. Hotaling & Murray A. Strauss, published 1987, Sage Publications, Beverly Hills, CA. Use of this material has been approved by the author.

society. The rapid growth in awareness of childhood sexual abuse as reflected in the family violence literature of the late 70's has evolved from the growing concerns of both health and social service professionals and the emerging feminist movement.

More recently, abuse and neglect of the elderly, frail or vulnerable adult has emerged as a pressing social concern, with both recognition and strategies for intervention in an early stage of development.

Understanding the Commonalities

Study reveals some similarities in these various forms of victimization, and clarifies cycles of violence involving victim and abuser, sometimes with reversing roles in differing situations or differing periods of the life cycle. Health professionals must be aware of these similarities in order to detect the different types of abuse within the same family, to prevent potential abuse of others by former victims, and to prevent the ongoing victimization of those who are abused in childhood.

The Offenders

Perceptions of the individuals who may be potential offenders has evolved from the view that individual offenders possessed various stereotypical characteristics or behaviours, to an understanding that offenders may come from all walks of life and are, in fact, relatives, neighbours and friends.

A common motivating factor in family violence appears to be the abuse of power based on the relative strengths of offender and victim — strengths that may reflect differences in physical, emotional, social, economic, gender or age position. In childhood sexual abuse, for example, the most widespread situation is that in which an older male abuses a younger female, thus exploiting two axes of power — gender and age.

Abusers appear to carry out the abuse to compensate for their own perception of their lack of power or control. Many offenders have often, themselves, been victims of, or witness to, abuse or violence, thus perpetuating the frightening cycle. In these acts of assertion of a tenuous or uncertain power, batterers and perpetrators of abuse usually project the responsibility for the abuse upon their victim.

The Victims

It is important to realize that anyone can be a victim; however, there are some commonly observed effects of victimization which often serve to perpetuate the cycle of victimization. For example, victims are often persuaded or convinced by their abusers into believing that they are responsible for their own victimization. This emotionally self-deprecating perspective is often most strongly entrenched when the victims perceive themselves as involved in a loving and dependent relationship with the abuser.

Blaming the victim is frequently reinforced by other family members and by society at large. If victims do try to reach out for support, the response on the part of family and society is often unreliable and suggests that the victim must have been responsible in some way. As a result, victims quickly become trapped in cycles of trying to improve their own behaviour and attitudes. As the violence continues they suffer increasing shame and humiliation in their inability to stop it.

For these reasons, victims are very unlikely to identify themselves. They tend to guard the secret of their abuse ever more vigorously and become progressively isolated. This tendency towards secrecy and denial often continues even after they have presented themselves or been brought to an emergency department or health service for medical treatment.

Victims report long-standing feelings of depression, self-contempt, and an inability to trust and develop other intimate relationships. Some victims become relatively successful survivors while carrying through life the scars and damage from their abuse. Others succumb to suicide, alcoholism and drug dependency in their unsatisfactory attempts to escape the agony of ongoing victimization.

Research and observations from front-line workers reveal that some victims of child sexual abuse become victims of wife assault in adulthood or turn to juvenile prostitution. Some male childhood victims of sexual abuse come to the attention of authorities as juvenile offenders. Further study may also reveal links between elder abuse and victimization earlier in life.

The Family Context

Certain family situations seem to foster the development of several kinds of abuse. Although research is not conclusive, health professionals need to be aware that a person who has crossed the

barrier of battering a spouse in front of children may well present a threat to the safety of the children. In addition, children experience trauma in witnessing the family violence in the first instance.

Some battered women are afraid to come forward to report their own victimization because they fear that their children, who are also victims of abuse, will be removed from their care. Abused elderly parents have sometimes been abusers of their children or may have fostered a violent context for the family.

Family abuse cuts across economic, cultural and social barriers, although aggravating factors have been discussed in the literature, including unemployment, economic deprivation and the abuse of alcohol. Families that for a variety of reasons become socially isolated are fertile grounds for ongoing abuse.

A family that is very dysfunctional and abusive may present a very cohesive and positive image to the outside world, successfully masking the abusive nature of the family interaction.

Shared Goals of Prevention and Rehabilitation

As we move forward toward increased preventive strategies and improved treatment and rehabilitation programs in response to these concerns, health professionals will be pivotal partners in an interdisciplinary approach. Medical research, which has, in the past, focussed almost exclusively on physical child abuse, will incorporate the findings of sociologists, criminologists and psychologists, to better understand the role of health practitioners in early identification and prevention, treatment and rehabilitation. There are important humanitarian reasons for advancing our theory and methodology by continuing to nurture an interdisciplinary response to problems of abuse, assault, neglect and family violence and by remaining alert to the commonalities among these concerns.

3. INTERDISCIPLINARY APPROACH

Programs for identification and intervention in abusive situations require that professionals from various disciplines work in close cooperation as a team in serving appropriately the complex needs of victims and abusers. Consideration must be given to such diverse factors as medical care, safety, housing, financial assistance and, above all, immediate personal and social support once the

nature of the abuse has been disclosed. These diverse concerns require that staff work comfortably in an interdisciplinary approach.

Similarly, responses to most instances of abuse may place staff in a working partnership with a broad spectrum of community resources and services. It is important to make as much use of such resources as possible and avoid duplication of services or programs.

There are thus two very significant aspects of programming to be considered:

- interdisciplinary team work, and
- community collaboration.

Both these essential components of program planning are discussed more fully in the CONCLUSION, page 87 to 89, along with a more detailed discussion of the functioning of coordinating committees for both the planning and implementation of programs in these areas.

4. TRAINING AND EDUCATION

From the media or from first-hand experiences with victims or abusers among their family or friends, most health care staff have some general familiarity with the field of family violence. These impressions or experiences are rarely sufficient to prepare them for the challenging tasks of identification and intervention that will be required of them in their positions. In many instances, personal fears or attitudes can be an impediment to providing adequate service to those involved. In-service training will be of crucial importance in helping staff acquire the skills and abilities needed to function effectively.

The field of family violence is developing very rapidly. Materials and various training aids are becoming available. This document has been expanded in some areas beyond the usual "guidelines" publications with a view to supporting training initiatives during this developmental phase. Other materials are available from provincial and local resources - governmental, voluntary and professional. At the federal level, information on resources is available from the National Clearinghouse on Family Violence, Department of National Health and Welfare.

Both program staff and trainers will need some direct experience in the field of family violence if they are to initiate either service or educational programs. Exchanges with other facilities, attendance at workshops and training programs, regional collaboration and shared resources with community advocacy and service organizations provide excellent resources with which to begin.

5. USE OF THESE GUIDELINES

It will not be possible to achieve all the objectives outlined in this publication immediately. The task may seem formidable, particularly if it is unfamiliar to many staff members. These guidelines, however, serve as a starting point for program development.

Each institution has its own needs and resources. It should be realized at the outset that the development of a full program is a gradual process and, because of the nature of the issues, will involve ongoing planning.

■ CHILD ABUSE, INCLUDING CHILD SEXUAL ABUSE AND ASSAULT[4]

1. INTRODUCTION

1.1 Why are these Guidelines Important?

These guidelines will assist institutions in meeting statutory obligations and other requirements, the needs of the children in the community who are being or may be abused, as well as the needs of their abusers. They are designed to facilitate the development of an individualized protocol for the identification and management of child abuse.

1.2 Definitions

Child Abuse

Definitions of child abuse in provincial legislation are generally similar across the country. However, it is extremely important that policies, procedures and protocols for each facility be developed in consultation with appropriate provincial or local child protection and law enforcement authorities. An interdisciplinary approach should be taken; regional and community resources should be considered in planning; and victim support and advocacy groups should be involved.

Child abuse consists of any non-accidental injury or harm to a child by a person having charge of that child or caused by that person's failure to care and provide for or supervise and protect the child adequately.

Child abuse includes: physical, sexual and emotional abuse, as well as neglect and substantial (or high) risk of any of these. With respect to the reporting requirements, risk of abuse or neglect may be described as the reporting of a child in need of protection.

4 See also MEDICOLEGAL ISSUES, page 81.

Physical Abuse

Physical abuse consists of any non-accidental form of injury or harm, inflicted on a child by a person having charge of that child. Physical abuse includes beating, burning or wounding. The use of a closed fist or instrument, kicking, throwing or shaking a child constitutes physical abuse under any circumstances, whether or not that incident caused internal injuries. Corporal punishment which injures the child to the point where medical attention is required is outside the limits of normal corrective discipline. Such injuries could occur in an institution as well as the home.

Sexual Abuse

Sexual abuse is the involvement of a child, with or without the child's consent, with an adult (or age-inappropriate adolescent) within the family (intrafamilial) or outside the family (extrafamilial) in sexual behaviour designed for the gratification of the adult or older adolescent, whether heterosexual or homosexual. It includes manual, oral, anal, genital, buttock or breast contact or the use of objects for sexual penetration, fondling or stimulation. It also includes exploitation of the child for pornographic purposes and making a child available to others as a child prostitute. Inappropriate solicitation, exhibitionism and exposure of erotic material for the intention of stimulation are also included in this definition.

Emotional Abuse

Emotional or mental abuse is probably the most difficult type of child abuse to define and to identify. It leads to psychological as opposed to physical harm of children. It would include a parent or caregiver's constant and continual overt rejection and criticism of a child, as well as repeated belittling or openly disowning of a child. Emotionally abused children sometimes have unreasonable demands for competence placed upon them. These children are frequently threatened and racked by fears. They may be constantly told they are evil, bad, worthless, or hated. A commonly used term is the "scapegoating" of these children. There is a component of emotional abuse co-existing with physical abuse in most child abuse cases.

Neglect

Neglect consists of omission on the part of the parent(s) or caregiver(s) to provide the basic needs such as food, clothing and shelter to a child. It also includes inadequate parental supervision to

prevent injury; abandonment; failure to provide medical attention when required or the withholding of medical attention when required. Also included is the category of "failure to thrive", wherein a child can fail to get adequate nourishment for a variety of reasons. It may be determined that the child has organic problems or non-organic problems; or, the cause of "failure to thrive" may remain undetermined. Thus, conclusive evidence that "failure to thrive" is a result of neglect requires thorough and preferably experienced medical assessment.

Substantial Risk

Children are considered to be at substantial risk of physical, emotional, or sexual abuse and/or neglect if they were victims in the past, or if one of their siblings was or is a victim. In addition, children can be deemed to be at substantial risk because of particular characteristics of their parent(s) or caregiver(s).

Abusive Relationship

Those responsible for child abuse include guardians, members of the child's family, and individuals in positions of trust in the child's life, as well as acquaintances and strangers. Many of the perpetrators were themselves abused as children.

2. ROLE OF HEALTH FACILITIES IN MEETING THE NEEDS OF VICTIMS AND ABUSERS

Health facilities and their personnel play an important role in the prevention and treatment of child abuse.

Each health facility should develop a statement of philosophy prepared in consultation with the child protection authorities. This statement should recognize the shared responsibilities of health and child protective services and should be based on the principles of "the child's best interest" and "the least restrictive or disruptive intervention" required for the child's protection. The statement might also include the following:

- Early identification, clear documentation and clear reporting are essential in protecting children from serious abuse;

- Prompt and effective response is important for the immediate protection of any child suspected of being a victim of abuse, whether this response is through early consultation by the health facility with child abuse authorities, or through alternate immediate interventions in accordance with established policies and procedures in situations presenting acute emergencies;
- Provision of treatment, rehabilitation and/or advocacy services to help the family unit continue to meet its responsibilities by creating a safe and healthy environment for the child is considered an essential goal; and
- Collaborative and cooperative interdisciplinary team effort in identifying, assessing, treating, managing and preventing child abuse is the optimal method to achieve the purposes of all concerned.

Each health facility should look at its own community needs in order to determine how it can best serve the needs of the child and family within that community. Specific consideration should be given to promote communication among the facility, child protection services, police, justice, education and public health systems, as well as self-help advocacy and victim/ parent support groups and community-based programs. The facility should consider its role in child abuse education for its own personnel, community professionals, and the lay public. It should also consider its role in conducting research and assisting in its application.

The governing board should make provision for financial support for programs that are developed as a response to these considerations.

3. PROGRAM GUIDELINES

3.1 Space Requirements

Adequate space is required to allow privacy for interviewing, examining and treating children and their families. This environment should be comfortable and non-threatening. Depending on the scope of the program, space should also be provided for authorized observation of appropriate interviews and videotaping, if and when necessary. Adequate office space for the personnel involved must also be provided.

3.2 Personnel Requirements

It is recommended, as stated in the philosophy section, that a interdisciplinary approach be used to child abuse. With such an approach, each profession has its own specific and important role and its own expertise. Each profession's responsibility includes education, research, advocacy and provision of good role models. Individuals must be aware of their own roles and those of other professionals involved. The combined expertise of all is necessary for appropriate assessment and treatment of child abuse.

Roles of Staff Members

Staff members who share responsibility for the child abuse programs include, among others: the administrator, physicians, nurses, social workers, program or committee coordinator, staff educator, and psychologist.

A general list of possible task assignments in the program for staff members is contained in APPENDIX III - SUGGESTED ROLES FOR STAFF, page 94.

The roles outlined provide a general guideline only and should be adapted to the situation at each facility.

Committee Functions

An interdisciplinary child abuse committee can provide a broad perspective on the overall management of child abuse along with the necessary emotional support of other professionals in dealing with complex cases.

Each new committee being developed will need to reach agreement on its own goals and purposes. Generally, committees focussed on the identification and management of child abuse cases consider the following goals:

- identification and referral of suspected cases of child abuse
- case assessment and/or consultation service
- formulation of treatment plans and/or provision of treatment and case management, and
- review of ongoing cases of child abuse.

Some institution-based committees carry out all of the four functions listed above. In addition, some committees provide an education and/or evaluation function, including the development of policies and procedures regarding child abuse within the facility. They may make representation to the administration and the governing board to secure funding for appropriate programs.

The purpose and function of each committee depends on how its particular needs are defined.

Committee Membership

Membership varies according to the purpose and function that an individual committee develops. The following is a suggested list of disciplines:

PHYSICIANS	Paediatrician Family Physician Emergency Physician Child and/or Adolescent Psychiatrist
SOCIAL WORKER	Hospital Children's Protective Services Mental Health Clinic
NURSES	Paediatric Emergency/Ambulatory Care Public and Community Health
OTHERS	Educational Representative Police Officers or Crown Attorneys Legal Representatives Day Care Representatives Hospital Administration Representative Psychologists and other Mental Health Professionals

3.3 Planning and Direction - Policies, Procedures, Protocols

Each health facility should develop its own policies, procedures and protocols to establish the details of management in child abuse cases. The following issues should be addressed.

Purpose

The purpose of child abuse management including early identification, intervention, protection and treatment must be stated clearly.

Identification

Identification and immediate referral to a Child Protection Service leads to early intervention and could prevent more serious abuse and/or death of a child. It is therefore recommended that a clearly defined mechanism for initial screening, assessment and reporting of suspected child abuse cases be developed and instituted within each facility in advance, in order to avoid unnecessary delays and to ensure that all suspected cases are reported to the Child Protection Service.

Since cases may be identified anywhere in any department, there should be a procedure in place to allow follow through regardless of where these cases are identified.

Duty to Report

Policy must clearly state that all health care personnel have a duty to report, and that confidentiality requirements are superseded by legislation requiring mandatory reporting of child abuse. Reference must be made to the appropriate provincial legislation stating:

- the definition of the different types of child abuse and risk situations
- what information is reportable, and
- the timing of the report.

Further, the policy must state clearly:

- the mechanism for reporting
- the staff person responsible for reporting, and
- the mandated agency to be notified with up-to-date names and numbers.

Child Abuse Committee

If an institution-based committee exists, there must be clearly stated procedures and protocols that include:

- purpose
- terms of reference, i.e. parameters of accountability
- membership
- role of each member
- time and location of meetings
- referral process including emergency procedures
- assessment and decision-making process
- reporting process
- record keeping, and
- relationship to child protection agencies, police, appropriate religious personnel, family doctor, and other appropriate authorities.

Consent

The procedure for obtaining legal consent for medical care, including instances in which parental consent is withheld, should be clearly outlined. It is important to determine the child(ren)'s legal guardian and that individual's relationship to the child(ren).

Records

It should be clearly stated that data must be clear, concise, accurate and complete, as medical records related to child abuse are likely to be required in court as evidence. The concept of protecting the chain of evidence is very important with respect to lab specimens. The procedures followed in each specific instance need to be clearly recorded in the medical record to protect the validity of evidence.

Forms

There should be adequate and clear instructions for the use of relevant forms.

Confidentiality

There should be a clear statement on what confidential information pertaining to child abuse can be released to parents and/or other appropriate authorities in accordance with provincial legislation and regulations.

Resources

Relevant resources should be clearly listed with up-to-date contact names and numbers. Emergency consultants and shelters should be clearly identified.

Refer also to page 91, APPENDIX I - POLICIES AND PROCEDURES CHECKLIST, for a guide in developing program policies and procedures.

3.4 Evaluation

An evaluation program must be in place to ensure that child abuse cases are being addressed promptly, efficiently and compassionately. The evaluation should include staff problems that may be associated with this stressful activity.

Scheduled interdisciplinary reviews of child abuse cases are important to maintain coordinated care. This should be accomplished in accordance with the health facility's quality assurance program. Follow-up with the family and child protection agency is essential to ensure that appropriate support for the child and family has been offered, either within the institution or by referral to an appropriate community service.

The evaluation process must identify the areas in which continuing education must be developed and maintained to ensure the effective functioning of the program.

There should be evaluation of the relationship of the various agencies in order to ensure that such relationships exist, or that they are developed to the maximum potential.

Refer also to page 92, APPENDIX II - CHECKLIST FOR CARE AUDITS for assistance in planning Evaluation and Quality Assurance.

3.5 Prevention

A health facility can act as community leader and resource in areas of child abuse by establishing standards of child care in this area.

This can be done by:

- providing staff and/or space for parenting classes or self-help groups;
- encouraging or establishing programs aimed at parent support and relief;
- developing links to community-based efforts intended to improve parenting, child safety and related issues;
- assisting family physicians to find resources for their patients.

A facility can provide public education as well as outreach services to specific families. In high risk cases, intervention and support is necessary.

Patient advocacy within the institution will ensure that the facility adheres to the principles which provide for the child's best interest and safety.

3.6 Care, Treatment and Continuing Management

The protocol (see Samples, p. 24) should address the care, treatment and ongoing rehabilitation required in suspected child abuse situations. It must stress that at every step the child's welfare must be the first priority.

This means that:

- protection of the child is the primary consideration
- child and family must be treated sensitively and patiently, though expeditiously, and
- child's medical management takes priority over forensic specimen collecting.

There should be a mechanism in place to provide back-up staff when necessary in the emergency department to allow sufficient time for the optimum examination and care of abuse victims and their families.

The protocol should clearly outline all aspects of the examination, including history taking, physical examination, collection of data, treatment, reporting, consultation, disposition and follow-up.

History-taking should be directed at determining the specifics of the allegation or the presenting incident and the attendant medical symptoms. The parents and child(ren) should be interviewed separately whenever possible. Statements, particularly from the child, should be recorded verbatim. It is important to avoid multiple interviews of the child. The use of leading questions should be avoided.

Because both the physical examination findings and the history as given by the child and others involved will be used as evidence in court, it is important that the procedures and protocols be clearly established in advance. This should be done in consultation with both the child and protective and law enforcement authorities so that any questions with respect to the integrity of the chain of evidence or the nature of the history-taking can be anticipated in advance. Particularly with child sexual abuse, practices and expectations of the law enforcement and judicial system may vary. These requirements should be anticipated and incorporated into policies and procedures by consultation at the planning stage. In some jurisdictions, law enforcement officials prefer to be involved in planning the disclosure interview where time permits, as, for example, when a child is to be seen by appointment on referral following disclosure of child sexual abuse. To validate the interview, some facilities videotape the interview or have a law enforcement officer observe through a one-way screen.

The physical examination must NEVER be done against the child's will and the child must NEVER be restrained for it. If the examination is medically indicated, e.g. the child is bleeding from the vagina, and the child's cooperation cannot be obtained, the examination should be carried out under anaesthesia. The child's cooperation can be obtained in most cases through patient explanation and gentle handling of the child. The examination should be head-to-toe and include assessment of the child's growth and development, as well as the fundi and genitals. All external injuries should be described accurately and precisely, preferably using a skin map. (See pages 36-37)

Laboratory data pertinent to the situation should be obtained. This includes material needed for the child's care, e.g. sexually transmitted disease swabs, as well as forensic evidence. For the latter specially designed provincial kits are available and should be used as directed. Generally kits are unnecessary except in acute sexual

assault with semen deposition. Some modifications or deletions to the kit may have to be made for use with the paediatric patient.

A determination that there are reasonable grounds to suspect child abuse, or the likelihood of the risk of child abuse or of a child in need of protection is sufficient to warrant a report to the mandated authorities.

Appropriate medical and psychosocial follow-up should be arranged in collaboration with the family physician, child protection agencies and mental health services as appropriate. This includes a duty to provide or arrange for appropriate counseling and ongoing rehabilitation for the victim, the offender and other family members affected by the trauma of child abuse.

Sample guidelines/protocols and forms from the Ontario Hospital Association manual "Child Abuse: A Protection Manual for Hospitals of Ontario" have been included for reference, pages 24 to 38. These are reproduced with permission as examples of the types of protocols and forms required to implement child abuse programs. Clearly, these specific protocols/forms are not directly applicable outside of Ontario. Other provinces have or are developing province-wide guidelines or requirements.

3.7 Education

Undergraduate and graduate level training of students enrolled in health care and allied fields should be provided.

Continuing education for employees ensures a high profile for issues and indicators of child abuse. Guidelines for the care and management of child abuse situations should be available to all facility staff. Opportunities should be made available for upgrading of skills with respect to these issues by educational seminars, workshops, conferences and other means.

3.8 Research

Support and encouragement for research into the various aspects of child abuse and for the application of relevant findings is important.

3.9 Complementary Guidelines Relating to Child Sexual Abuse

The Department of National Health and Welfare has also released two publications addressing the needs of community workers and clinical and technical aspects of the medical examination of children suspected of having been victims of child sexual abuse.

SAMPLE PROTOCOLS/FORMS[5]

7. PROTOCOL FOR THE IDENTIFICATION AND MANAGEMENT OF CHILD ABUSE INCIDENTS

The purpose of this part of the manual is to describe those tasks which should be carried out whenever suspected child abuse cases are encountered. The information is meant to assist hospital staff in identifying and managing suspected child abuse cases. As with the information given in Section 6 on types of child abuse, the information in this part is intended to assist hospital personnel in reaching a decision as to whether there are grounds for suspecting child abuse, not in proving it. Further assessment and/or investigation remain the responsibility of the CAS in your local area.

All types of child abuse can be combined for history-taking, medical management and follow-up. For operational definitions and descriptions of physical, behavioural and social indicators, refer back to Section 6.

7.1 History-Taking

During the history-taking in all five categories, it may be helpful to keep in mind that there are three possible referral sources:

(1) families may bring a child to hospital for examination and/or treatment;

(2) physicians or other professionals may request the service;

(3) other authorities such as CAS may present a child for examination and require documentation from hospitals.

History-taking is an extremely important part of any examination conducted in a suspected case of child abuse, since the decision that you have "reasonable grounds to suspect" can seldom be based on medical findings alone.

The history-taking will vary according to the situation, in keeping with the principles and philosophy outlined on page 11.

5 Ontario Hospital Association, "Child Abuse: A Child Protection Manual for Hospitals of Ontario", Toronto, 1987, pages 35-39 and 49-57. Note that cross-references within these samples refer to sections of the Ontario Hospital Association document, and that CAS refers to the Children's Aid Society.

If you are the first to be in contact with the family members, you will need enough information from your history-taking to make a decision on whether there are sufficient grounds to report your suspicions. If, however, an in-depth history has already been taken by he CAS protection worker, you may need to ask only a few clarifying questions.

The following general guidelines for history-taking from the parent and the child can be used for all types of suspected abuse, but you will need to adapt it to your own particular circumstance and situation. Professional roles are designated in this guideline but they too are to be adapted to your own specific setting and function.

7.1.1 History-taking from Parent (done by SOCIAL WORKER, PHYSICIAN or NURSE)

Incident

- verbatim description of how the incident or injury occurred, including time, place, situation, persons involved, and date
- how did parent(s) and child deal with incident or injury?
- was threat of violence or violence used?

Family Details

- family members' response and attitude to incident or injury
- children in home now (age, sex, number)
- marital status/adults in home/other care-takers of child (relationship to child)
- substance abuse or any other relevant stress factors in home
- history of CAS involvement in family
- mental and emotional health of parent(s) or care-taker

Medical Information

- previous hospitalization of child
- prior illnesses and injuries of child
- present health of child (including pertinent symptoms)
- immunization history

7.1.2 History-taking from Child (done by SOCIAL WORKER, PHYSICIAN or NURSE)

If child is old enough to separate from parent(s) (4 years approx.), see the child separately for interview.

- Identify who you are as a helping person.
- Establish appropriate relationship with the child prior to discussing abuse incident and/or injury.
- Ask child if he or she knows the reason for coming to the hospital.
- Ask child to describe in own words (and language) what happened or is happening to him/her.
- Reassure child that you believe this and will get help, but avoid unrealistic reassurance, i.e., "you do not have to return home".

Continual emotional support of child is very important during history-taking.

If child is under 4 years or is non-verbal, you may wish to use other means of communication, depending upon the type of suspected abuse (i.e., anatomically explicit dolls, drawing materials, or books), or you may wish to consult a specialist in the area of interviewing small children.

7.2 Physical Examination

7.2.1 Preparation, Examination and Consents (done by PHYSICIAN or NURSE)

- *Explain the medical examination* to parent(s) or legal guardian(s) and child.
- *Obtain the necessary consents from parent(s). If child is around 14 or 15 years of age, it is advisable to obtain the child's consent as well.* If consent is refused, proceed as in Section 7.5, under " OPTIONS II" and "OPTIONS III".
- Some children (particularly those who have been sexually abused) may refuse to undress or submit to examination. Reassurance can overcome this. If not, and the child is apparently in need of urgent assessment and treatment (e.g., because of vaginal bleeding), the examination should be carried out under general anaesthesia. Otherwise the exam should be postponed to the earliest time convenient to all involved. The child should never be held down forcibly and examined.

- Some children may want to have a parent or other trusted adult present during the physical exam. Others, particularly adolescents, may prefer to be alone with the examiner.
- Although it is *advisable to have another professional present in the room during the physical examination*, the examiner may choose to accommodate the wishes of the child (as stated above).
- *It is extremely important to provide emotional support to the child throughout the preparation and during the physical examination.*

7.2.2 Examination (done by PHYSICIAN)

A careful and complete head-to-toe examination is essential for documentation. Special attention should be paid to the following:

- Measure height, weight and head circumference and plot them on the appropriate growth charts.
- Document size, colour, shape and location of visible injuries (old and new) on Injury Skin Maps.
- Make fundoscopic exam on a child under two (look especially for retinal haemorrhage on any child with head injuries).
- Examine the oral cavity.
- Record stage of pubertal development (Tanner staging - see Appendix 1).
- Examine the genitals and anus completely* but avoid unnecessary invasion. An internal exam is not indicated unless vaginal or other internal trauma is suspected. The use of a magnifying glass and light or colposcope is recommended. Use Sexual Injury Skin Map (Appendix 3 C).

Record genital anatomy and document clearly all positive and negative findings. Comment specifically on size of vaginal introitus, appearance of hymen, anal tone, signs of trauma or irritation, or the presence of foreign substances.

- Describe the child's observable behaviour.

7.3 Collection of Data (done by PHYSICIAN)

- Sexually transmitted disease cultures* (throat, vagina, cervix, urethra and rectum); baseline serology.
- Forensic specimens as indicated in the Sexual Assault Evidence (SAE) Kit supplied by police (although this is most useful if evidence is collected

* Indicated in children who are suspected to be victims of sexual abuse.

within a 24-hour period, the SAE Kit can yield useful information up to 48 hours after the sexual assault has occurred).

- CBC, bleeding studies and other blood work as necessary.
- Urinalysis.
- Pregnancy test* if indicated.
- X-rays - as indicated by physical exam (skull and long-bone survey and/or bone scan should be considered in child under five years).
- Coloured photographs as necessary.

7.4 Treatment (done by PHYSICIAN and NURSE)

- Treatment of abrasions, lacerations, fractures or internal injuries, etc., as indicated.
- Tetanus prophylaxis as needed.
- Preventive treatment* for sexually transmitted diseases (should be considered and, if necessary, child should be followed up at a later date in the clinic, for serology).
- Pregnancy prophylaxis* (should be considered in post-menarchal and immediately pre-menarchal girls regardless of the timing of the sexual abuse in the menstrual cycle).
- *Reassurance regarding findings, emotional support and arrangements for follow-up.*

7.5 Reporting (done by PHYSICIAN, NURSE or SOCIAL WORKER)

A decision must be made as to whether or not you have *reasonable grounds to suspect child abuse based on (1) medical findings, (2) explanation given, and/or (3) other information given (previous hospital records, CAS, police, etc.)*

If you have reasonable grounds to suspect that child abuse has occurred two considerations must be kept in mind, (1) the safety of the child, and (2) the duty to report. Your course of action will depend on your perception of the parents, their availability and the degree of cooperation you receive. The following are three options.

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* Indicated in children who are suspected to be victims of sexual abuse.

OPTIONS

I	II	III
Co-operative Parents/Parents/ Guardians	**Potentially Non-Co-operative or Absent Parents/Guardians**	**Non-Co-operative Guardians (Note: Different Sequence)**
1. Notify hospital child protection team or designated person *forthwith* (phone: _____)	1. Notify hospital child protection team or designated person *forthwith* (phone: _____)	1. Do not obstruct parents or custodian from removing the child from hospital if they insist on doing so against your professional advice, but immediately inform the CAS in your area (phone: _____). Notify CAS that parents/guardians are non-co-operative.
2. Discuss with child and child's parents or legal guardian the fact that you are required by law to report any possible non-accidental injury or harm to the CAS (if child is under the age of 16 years).	2. Notify the CAS in your area (phone: ____) or have someone else do so while you are talking with the child's family, in order that CAS may reach the hospital before parents or guardians leave. CAS may wish to apprehend the child.	2. Immediately inform the police (phone: ____) if danger to child appears imminent.

3. Notify the CAS in your local area (phone: _____). Refer case to appropriate CAS intake worker. *Do not leave message at switchboard.* Consult with worker what action will be taken.	3. Discuss with parents the need to hospitalize child. Use your own discretion in the way you present the situation to the child's family, but keep in mind the importance of obtaining their consent for hospitalization of the child, so a full evaluation can be made. If consent is obtained (see Appendix 2) proceed to No. 4 below. If not, see section on Non-Co-operative parents (Option III).	3. Notify the hospital child protection team or designated person.
4. Advise parents/ guardians of planned CAS involvement.	4. Proceed with hospitalization of child if indicated.	4. Advise hospital Chief Executive Officer or designate. (phone: ____)
5. Proceed with hospitalization of child if indicated, with consent of parent or guardian (or child, if appropriate - see Appendix 2)	5. After the child is admitted, discuss with both the child and the child's parent(s) or legal guardian(s) your concerns about the child. Inform them that you are required by law to report to the CAS any possible non-accidental injury or harm.	5. Follow hospital policy re emergency consents and medical treatment. (See Appendix 2.)

7.6 Consultation (done by PHYSICIAN)

The following consultation services may be requested:

- *social work* assessment (necessary in all cases to evaluate the family situation)
- *psychiatric* assessment as indicated
- *psychological* assessment as indicated
- *paediatric* assessment as indicated
- *public health nurse's* assessment as indicated

7.7 Disposition (done by PHYSICIAN)

After consultation with the CAS protection worker:

- *Discharge to responsible person* (identified in your note) with *further evaluation to be carried out by the CAS*; or
- *Discharge to responsible person* (identified in your note) *with CAS supervision*; or
- *Discharge to CAS.*

7.8 Follow-up (done by PHYSICIAN, NURSE, SOCIAL WORKER OR PUBLIC HEALTH NURSE)

- Appropriate follow-up arrangements for both *medical care* and counseling should be made. Referrals can be made through hospital facilities, primary care physicians, CAS or other community agencies.
- The timing of follow-up appointments should be determined *prior to discharge*, if possible.
- The follow-up *plan should be documented on hospital chart.*

APPENDIX 2 - GUIDELINES FOR SPECIFIC CIRCUMSTANCES

(a) Consent

In every case, attempts should be made to obtain consent from a parent or lawful custodian, because a hospital cannot legally permit medical examination or treatment of the child without consent. Treatment should not be given to a child whose parents refuse to consent to the treatment. The EXCEPTIONS are outlined below.

Medical Examination

If the parents refuse to give consent or are unavailable to do so, *the CAS worker has the authority, if the child is apprehended,* to give consent for the medical examination of the child. Apprehension by the CAS is discussed in Part (b) of this Appendix.

Medical Treatment

In the case of an emergency where the parent or appropriate person is not available to consent to treatment and delay in obtaining consent would result in imminent and serious harm to the life, limb or vital organ of the patient, the physician has the duty to do that which is immediately necessary to treat the patient.

If a young person is not mentally capable of consenting to proposed treatment or legislation does not permit a person under 16 to consent to treatment, and if a parent or guardian refuses to consent to care or treatment that is essential to the life or health of the child, and the child is, therefore, in need of protection, appropriate legal action may have to be instituted to obtain consent.

The CAS worker *does not have* the authority to sign for surgery, anaesthesia, or other medical procedures, *except in cases where the child is a society or crown ward.*

Photographs of Patient

Coloured photographs of the child's injuries will be taken by the designated hospital photographer *only when ordered by the attending physician.* The child's name and date should be included in the photograph when taken, otherwise a sworn affidavit to prove identity may become necessary.

The patient's health record must contain the physician's written order for the photographs and a consent form signed by a parent having legal custody of the child, a legal guardian or a CAS representative (Appendix 3 D is a sample form).

The health record must also contain appropriate documentation and a complete description made by the attending physician of the injuries. Identifying information should include the patient's name, registration number, and the date the photograph was taken. The medical record should also contain the names and locations of both the photographer and the developer of the photographs.

Photographs and their negatives ordered by physicians and taken by a hospital photographer become part of the health record and their confidentiality must be maintained.

Photographs and their negatives taken by the CAS or the Police remain the property of those organizations.

* * * * * *

(d) Child Protection Screening Form (CPSF) - Sample Guidelines

1. The CPSF (Appendix 3 A) is designed to be one part of the evaluation process undertaken in the detection of child abuse in the hospital. It provides an opportunity for medical staff to *record observations of a behavioural or attitudinal nature that may be indicators of child abuse.*

2. The CPSF is filled out in the Emergency Department or other designated units by the physician or other medical personnel. The screening form is for *observational purposes* only.

3. The CPSF is filled out in all cases of *"high risk" home accidents including poisonings, ingestion, overdoses, burns and scalds, falls and accidents.* It is also filled out in cases of *sexual abuse, emotional abuse* and where the child shows evidence of *neglect.*

4. The CPSF is not filled out in cases where children are injured in *automobile accidents, or school or sports accidents.* However, if there is an element of the parents' *"failure to provide"* in these instances a *form should be filled out.*

5. *A system for regular review of CPSF* should be established by the hospital.

6. All forms are *filed in the Emergency Department* to ensure confidentiality and for future reference. This allows the emergency staff to determine whether or not a pattern of injuries is occurring. It is for this reason that it is essential that a form be filled out even in those situations where no immediate concern is present.

7. *Completion of the CPSF does not constitute reporting of suspected child abuse. A phone call must be made to CAS (phone: _____) if child abuse is suspected.*

8. Hospital personnel will be notified if the case is to be scheduled for a conference.

9. *CPSF data are used to keep accurate statistics* in the hospital on numbers of cases of various types of child abuse.

10. Hospitals may wish to institute a *coding alert system* to assist in identifying children who are brought to hospital frequently.

Substantial Risk Observation Form

This form (Appendix 3 E) as designed to be used in the obstetrical unit (labour and delivery), in the paediatric unit, and in any other ward in the hospital where observations of a patient may assist in detecting a substantial risk situation for a child.

Some hospitals in Ontario already make use of observation forms in order to detect the future safety of children. Frequently, hospital personnel work closely with a public health liaison nurse to request follow-up home visits. In extreme cases, the Head Nurse in Obstetrics or in the Nursery may attempt to prevent abuse of a child by making a referral to CAS before the parent and child are discharged from the hospital. This may happen if the parent shows marked bizarre or psychotic symptoms, or if other characteristics appear which would impair the parent's ability to provide for the physical and/or emotional needs of the child: e.g. a parent with a known substance abuse; a mother who displays abnormal postpartum emotional problems; a parent showing an abnormal lack of interest in the child or demonstrating harsh treatment while visiting the child in hospital. Such events should alert hospital personnel to the possibility of a substantial risk situation for the child.

APPENDIX 3 A CHILD PROTECTION SCREENING FORM

Complete this form on children under the age of 16 years.
Do not include auto injuries, or sport injuries.

Date _____ Time _____

Child's name _____

Presenting injury and/or problem

D.O.B _____ M _____ F _____

_____ Custodial Parent(s) _____

_____ Address _____

_____ Phone (h) _____ (w) _____

_____ Who brought child in? _____

_____ Phone # _____

HAS THE CHILD:	Please Circle
Been the subject of a home accident? (a) fall (b) burn (c) ingestion (d) other (Pls. specify) ____	Y N
Shown evidence of dehydration/malnutrition, failure to thrive?	Y N
Shown evidence of neglect, i.e., poor hygiene, etc.?	Y N
Shown evidence of previous injury, i.e., fracture, bruising, poisoning, etc.?	Y N
Exhibited inappropriate behavior, i.e., fearful, aggressive, detached, bizarre?	Y N
Reported that s/he has been physically ill-treated?	Y N
Reported that s/he has been sexually abused?	Y N
Been seen in hospital facilities repeatedly?	Y N

HAS THE PARENT/CARE-GIVER:	Please Circle
1. Delayed unduly seeking medical attention/treatment?	Y N
2. Presented contradictory history?	Y N
3. Presented unsatisfactory or no explanation of injury?	Y N
4. Shown detachment?	Y N
5. Shown hostility?	Y N
6. Shown other behaviour not appropriate to the circumstances? (Pls. specify) _____	Y N
7. Been reluctant to give information?	Y N
8. Refused to consent to further diagnostic studies?	Y N
9. Reported that child has been abused or neglected?	Y N
10. Perceived the child as a problem?	Y N

OBSERVER'S IMPRESSIONS:

1. State reasons for concern _____

2. Please circle your degree of concern

1	2	3	4
**extreme	major	moderate	minimal

(** If extreme concern, immediate action must be taken)

3. Comments _____

ACTION TAKEN:

( ) X-rays ordered
( ) Specimens taken
( ) Sexual Assault Evidence Kit Used (#)
( ) Coloured Photos Taken
( ) Contacted family physician (specify name)

( ) Referred to Special Consultant (Specify) _____
( ) Admitted to Hospital
( ) Contacted CAS

SIGNATURE _____ **DATE** _____

APPENDIX 3 B

GENERAL INJURY SKIN MAP

GENERAL PHYSICAL EXAMINATION:

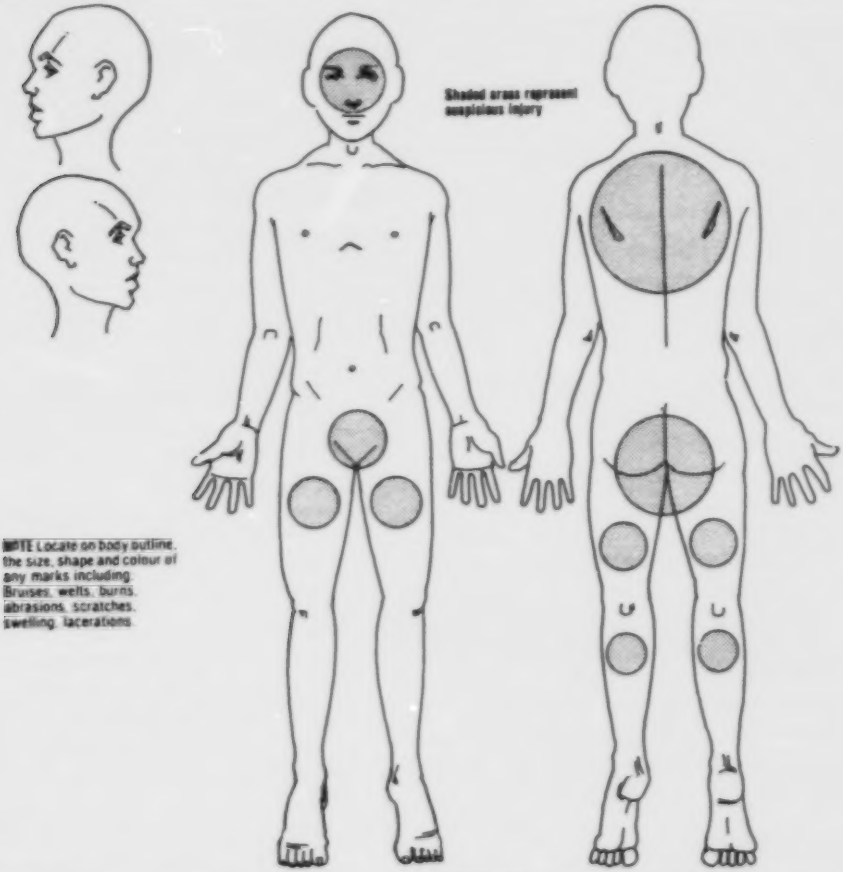
Height: _____ Weight: _____ Head Circumference: _____

General Condition: _____ Skin: _____

Eyes: _____ Ears: _____ Mouth and Throat _____

Chest: _____ Abdomen: _____ Extremities: _____

Neurological: _____ Genitalia and Buttocks: _____ Tanner Staging: _____



NOTE Locate on body outline, the size, shape and colour of any marks including: Bruises, welts, burns, abrasions, scratches, swelling, lacerations.

SIGNATURE _____ **DATE COMPLETED** _____

(Attending Physician)

APPENDIX 3 C

SEXUAL INJURY SKIN MAP

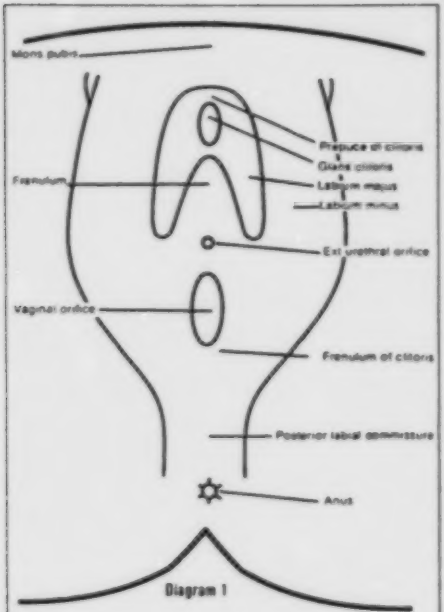


Diagram 1

Female External Genitalia
The Pelvis and Perineum

Note: Instructions for marking up Diagram 1

1. Draw in outline of hymen and note size of vaginal introitus.
2. Mark any injury indicating size, shape and colour location in genital area.
3. Indicate any abrasions, bruises or tears of the anus.

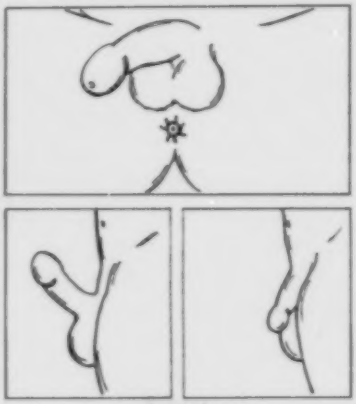


Diagram 3

A boy's penis in an erect state

A boy's penis in a flaccid state

Note: Instructions for marking up Diagram 3

1. Mark on outline any injuries to penis or other areas of genitals indicating size, shape and colour.
2. State whether circumsized
3. Indicate any abrasions, bruises or tears of the anus.

Female Breasts
Diagram 2

Note: Instructions for marking up Diagram 2

1. Indicate size, shape and colour of any mark or injury on front or side view of breasts as appropriate.
2. Indicate any other marks or injuries in breast area.

Child's Name _____

Date Completed _____

Completed by: _____
(Attending Physician)

APPENDIX 3 E SUBSTANTIAL RISK OBSERVATION FORM

This form may be used on admission, at discharge assessment, at weekly intervals, or as requested.

Please tick one or more responses and/or comment in space provided. Child's name: _____ Hospital No. _____

A Involvement with child

Is parent involved in:

	MOTHER Admission	MOTHER Subsequent 1	2	3	FATHER Admission	FATHER Subsequent 1	2	3
Holding	☐	☐	☐	☐	☐	☐	☐	☐
Bathing	☐	☐	☐	☐	☐	☐	☐	☐
Changing diapers	☐	☐	☐	☐	☐	☐	☐	☐
Feeding	☐	☐	☐	☐	☐	☐	☐	☐
Playing	☐	☐	☐	☐	☐	☐	☐	☐

Specify _____

Does parent seem:

	MOTHER Admission	MOTHER Subsequent 1	2	3	FATHER Admission	FATHER Subsequent 1	2	3
Loving	☐	☐	☐	☐	☐	☐	☐	☐
Uninvolved with the child	☐	☐	☐	☐	☐	☐	☐	☐
Frustrated by child	☐	☐	☐	☐	☐	☐	☐	☐
Hostile (physical/verbal)	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

Specify _____

B Reaction of parent towards staff

Does parent seem:

	MOTHER Admission	MOTHER Subsequent 1	2	3	FATHER Admission	FATHER Subsequent 1	2	3
Demanding	☐	☐	☐	☐	☐	☐	☐	☐
Guilty	☐	☐	☐	☐	☐	☐	☐	☐
Hostile	☐	☐	☐	☐	☐	☐	☐	☐
Withdrawn	☐	☐	☐	☐	☐	☐	☐	☐
Appropriate	☐	☐	☐	☐	☐	☐	☐	☐
Co-operative	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐

Specify _____

Reaction of parent to other parents

Does parent seem:

	MOTHER Admission	MOTHER Subsequent 1	2	3	FATHER Admission	FATHER Subsequent 1	2	3
Uninvolved	☐	☐	☐	☐	☐	☐	☐	☐
Talkative	☐	☐	☐	☐	☐	☐	☐	☐
Appropriate	☐	☐	☐	☐	☐	☐	☐	☐
Inappropriate	☐	☐	☐	☐	☐	☐	☐	☐

Specify _____

C Visiting or telephone pattern

Frequency of visits or calls per week: v (visits) or c (calls)

	1	2	3	4	5	5+
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐

Indicate average length of visit:

	10-30 min	30-60 min	1-1½ hr	2+ hr
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐
Other	☐	☐	☐	☐

Specify _____

Have the parents given any indication the child is not wanted?

If so, what did parent(s) say:

_____

_____

_____

Concerns stated by other relative(s)

_____

Date of admission _____ Dates of Subsequent Observation 1 _____ 2 _____ 3 _____

Signature (Admission) _____

■ SPOUSAL ABUSE[6]

1. INTRODUCTION

Based on information available to date, women are much more likely to be abused by their spouses than men, and are more likely to seek help as a result of the abuse. Although husband abuse occurs, it is infrequent and rarely reported. Facilities need to be sensitive to both types of abuse, while recognizing that most victims are likely to be female.

1.1 Overview

Spousal abuse is a widespread and long-standing social problem. Although the actual frequency of spousal abuse is difficult to define, there is clear evidence that it has permeated all socio-economic, cultural, and geographic boundaries. Like other forms of abuse, spousal abuse results in a host of secondary psycho-social problems that affect not only the abused, but all other members of the family unit, and the community.

Society's response to the issue of spousal abuse, to date, has not adequately met the needs of all victims. In fact, it has been only in the last few decades that laws which either sanctioned or tolerated wife abuse were dismissed. Typical of the contemporary response is to react only to individually diagnosed incidents and to disbelieve the general prevalence of spousal abuse. Those who acknowledge the prevalence of spousal abuse rarely acknowledge the probability that it occurs with some frequency among their own social groups. Another common attitude is to justify non-interference as respect for the sanctity of the family. Such attitudes allow long-standing myths regarding spousal abuse to remain unchallenged, and defy the mobilization of society's resources to confront the issue.

Society's helping institutions are not always well organized to respond effectively to the needs of spousal abuse victims and abusers. Health professionals appear to agree that the identification and management of all aspects of domestic violence requires an

6 See also MEDICOLEGAL ISSUES, page 81.

interdisciplinary approach. Health facilities need to support and clarify these interdisciplinary relationships in order to improve the quality of services, specifically coordination and continuity of care. Health facilities must also nurture a caring environment in which to receive victims. This caring environment, despite the best of intentions, may be difficult to maintain. Abused individuals may be victimized again by the lack of experience, knowledge and guidelines in health care settings.

Prevention of spousal abuse is a shared goal requiring coordinated efforts by various sectors and agencies. The need for better co-ordination of services to victims goes beyond the health system and includes the social services and judicial systems. Co-ordination of the efforts of these social agencies will lead to improvements in identifying high risk populations and individuals in order to find and help victims as soon as possible. Clearly the ultimate goal should be to prevent spousal abuse in the first place. No one sector or agency is totally responsible; nor is any one completely free of responsibilities in striving to prevent spousal abuse or provide services to victims and abusers.

1.2 Definitions

Abuse is the intent by one individual to control the behaviour of another through actual or threatened physical violence, psychological threats (including verbal threats and forced social isolation), or unwanted sexual activity. (See also SEXUAL ASSAULT, p. 55)

Conjugal violence and spousal abuse are terms used to describe violent or abusive behaviour between partners who are involved in an intimate relationship. This includes men and women who are married or living in common-law relationships and also includes homosexual male and female relationships.

Spousal abuse is one manifestation of the dynamics of an unhealthy relationship. The abuse is frequently initiated during the courtship phase, and may continue throughout the relationship and even after the victim has taken steps to remove herself from the abusive situation.

Wife assault, abuse, and battering are commonly used terms which reflect the fact that the majority of spousal violence is committed by male partners against their wives or girlfriends.

Interchangeable terms for spousal abuse include wife abuse, wife assault, conjugal violence, wife battering, inter-spousal violence, spousal violence.

1.3 Importance of Guidelines

Health facilities are recognized as playing a pivotal role, as a model for the community in providing resources, structures and an organizational philosophy attuned to the very real needs and problems of victims and abusers. Health institutions provide a system and structure in which health care providers can optimally use their knowledge and skills.

Health professionals have a responsibility to examine their own values regarding spousal abuse, to dispel the myths surrounding this issue, to increase their knowledge of the area and to develop appropriate intervention skills.

At present, in Canada few hospitals are organized to provide adequate services to spousal abuse victims and their abusers. These guidelines are intended to assist those involved in planning, organizing and operating programs in dealing with spousal abuse incidents. The purpose of the guidelines is to provide a point of reference for program structure. These guidelines are not intended to provide standards for the professional's clinical practice.

2. THE ROLE OF HEALTH FACILITIES

Health facilities play an important role in cases of spousal abuse since they are frequently the primary "helping" contacts available to victims and their abusers. They must ensure that appropriate policies, procedures and protocols are in place to support and guide the delivery of services to victims and abusers. In particular, policy and procedures must address the early identification of victims, prevention of secondary victimization and appropriate coordination of available services.

2.1 Principles Underlying Involvement of Health Facilities

Domestic violence affects not only individuals but society as a whole. Health facilities as "helping" organizations are committed to breaking the cycle of violence affecting victims and their abusers.

Once violence has started between family members, it probably will continue and may well escalate. Violence is unacceptable and the community, including its helping institutions, has the right and responsibility to intervene.

Prevention of domestic violence and provision of adequate services for victims and abusers are shared goals requiring coordinated efforts by various sectors and agencies.

2.2 Recommended Program Objectives and Elements

Provide Comprehensive Services to Meet a Multiplicity of Needs

Governing boards, in consultation with administrative, medical and health care staff, should identify the most appropriate mechanisms by which their personnel can respond to the needs of victims and their abusers. For example, small facilities may not have the resources to organize an interdisciplinary team to deal with cases of spousal abuse. They can, nevertheless, play a significant role in identifying cases and ensuring that victims and abusers are referred to appropriate resources either within or outside their community.

The facility should play a leadership role for the community by publicly acknowledging the problem's existence in their community, identifying their attempts to respond to the problem and joining in community efforts to secure the necessary support for victims.

Effective caregivers must treat victims and abusers as whole persons and attend to their physical, psychological and practical needs. Victims' needs range from requirements for protection, shelter and legal advice to the need for support services, counseling and medical treatment. In order to optimize benefits for clients, resources available to help victims and abusers in their community should be identified. Staff should collaborate with these organizations in a planned systematic manner.

The program should be developed so that the victim is the focus of the staff's attention. If the safety of other dependent family members is in question (i.e. children), provincial legislation should be used to direct appropriate intervention.

Educate staff to identify and intervene effectively

The potential contribution of health facilities to educate health professionals about the problems of domestic violence is significant. Educational initiatives should be aimed at improving service delivery through orientation and continuing education programs for health professionals. The goal of such efforts should be to help the staff learn about spousal assault and injuries, the reasons women stay in violent relationships and appropriate intervention techniques. Facilitating the acquisition of knowledge and skills by students and trainees in various health disciplines is also important.

Some battered women have severe injuries requiring emergency treatment or hospitalization. Identification of abuse in this instance may be more straightforward. However, many come for help with non-acute, ill-defined complaints to either emergency or non-emergency services. These victims do not disclose abuse as the reason for coming to the hospital. Even though the nature and history of the injuries point to non-accidental origins, the victim may mask the cause. The health professional's role at this point is to encourage self-disclosure using a facilitative rather than confrontational approach. The educational program for health professionals must include information regarding indexes of suspicion of spousal abuse such as verbal, behavioural, physical and situational cues, and a profile of the typical abuser.

Prevention of staff burnout by informing the staff of methods to cope with their feelings of helplessness and frustration, when dealing with victims of abuse, should be included in the facility's educational program.

Refer also to page 51, SAMPLE CHECKLIST FOR EDUCATION PROGRAM ON SPOUSAL ABUSE for assistance in planning the educational program.

Avoid Secondary Victimization of the Abused (blaming the victim)

Health professionals, despite their specialized role and education, are as susceptible to value biases and myths as any group. These biases may lead to secondary victimization of the abused. Health facilities and professionals must recognize the potential for secondary victimization and prevent it from occurring.

Secondary victimization often occurs when staff accept a victim's account of the cause of injuries as accidental and fail to

consider and investigate the possibility of spousal abuse when there is every reason to suspect it. There are a number of circumstances that should alert staff to explore the possibility of spousal abuse.

For example, if a patient is being labeled as neurotic, hypochondriacal or a malingerer because diagnostic results do not satisfactorily explain the multiple ill-defined complaints for which she repeatedly seeks attention, this should trigger any professionally trained team to explore family interaction and dynamics and, specifically, to explore the possibility of spousal abuse. Inability on the part of staff to appreciate the reality of spousal abuse can lead to frustration and a failure to deal with the client in a sensitive and caring fashion.

Failure to acknowledge the widespread existence of spousal abuse can result in failing to provide clients with resource options available in-house or in the community for immediate or future consultation. Availability of referral and resource information in waiting rooms may assist victims or offenders to discuss their difficulties more openly, by providing a strong message to both that spousal abuse is unacceptable, the victim is not to blame and community resources are available to help.

An unwillingness or inability to identify personal fears and lack of confidence or conviction in dealing with cases of spousal abuse can lead to paternalistic or maternalistic, judgmental or angry reactions toward clients on the part of normally caring professional staff.

Ensure Appropriate Referrals and Follow-up for Victims and Abusers

The extent and nature of service and follow-up programs will depend on the available resources and the policies of each facility.

Follow-up arrangements with regard to medical and psychological needs should be discussed with the client. This may well involve encouraging the victim to enlist supportive family members or friends in a follow-up plan. Examples of such social supports are family members, neighbours, friends and co-workers who are supportive and understanding. Specific information on follow-up discussions and information provided to the client should be noted in the medical records.

Policies should reflect a continuity of care philosophy by noting that referral can be made to hospital-based professional services as well as to community-based services.

Financial dependence is often the major factor preventing the abused woman from leaving her partner. Health care providers must know the appropriate social service agencies in their communities to which clients can be referred for financial assistance.

Victims may require emergency shelter and/or long-term housing. Staff should know about the services and intake procedures of the shelters in their communities, in order to provide accurate information to clients.

Victims of assault are entitled to access to services from the justice system. Staff must be aware of legal resources for victims in their community. In order to understand the court process and to help victims understand it, staff are encouraged to talk with victim support workers or court services staff about the process. Coordinating responses across social services, health and criminal justice systems is an important aspect of assisting victims to exercise their rights.

Hospitals or institutions should recognize the staff's need for up-to-date information on legal services for abused women. This includes access to telephone numbers and contacts in local legal aid centres, victims' assistance or advocacy programs which assist battered women in their dealings with the criminal justice system.

An up-to-date list of local resources should be maintained and made available to appropriate staff to facilitate proper referral. This list should include the telephone number of various agencies and brief description of their roles in providing services. Typical agencies to be included on the list are transition houses, police, legal, social services, self-help groups, advocacy groups, appropriate religious personnel, community health groups, programs for battered women and alcohol and drug programs. Agencies and services can change their focus, develop long waiting lists and alter their fee structures. Therefore, it is important to up-date and verify referral information on a regular basis.

Pamphlets and information can be obtained from many sources and should be displayed and made available.

Since much of the verbal information given to a client during a crisis situation is not retained, printed information sheets to supplement and reinforce verbal information are important resources. In

some cases of suspected abuse or cases of confirmed abuse, the client may not want to take immediate action. However, they should be provided with written information regarding available community resources in case they decide to consult them in the future.

Provide Coordinated, Well-defined Response Networks

Coordination of services across agencies is crucial. Ideally, the assistance provided by different agencies should be complementary and coordinated in order to provide maximum support and minimal stress for the victim. Health facilities are integral components of interdisciplinary efforts to prevent all forms of domestic violence.

Intervention plans involving services both from within and outside a facility should clearly outline the roles and responsibilities of each professional and/or agency as well as how they interface. It is also important that this plan acknowledge the role played by clients themselves in the care process.

A coordination mechanism such as a Domestic Violence Advisory Committee is beneficial. Membership should not necessarily be limited to staff members of the facility, but could also include representatives of the various professional and community groups providing services. The terms of reference should reflect the institution's philosophy and resources. The committee would serve to advise on general issues related to domestic violence and on development of policies, procedures and protocols, to promote an interdisciplinary team approach, to support educational and research efforts, and to advise and assist in evaluation of programs and overall community response.

Play an Active Role in Prevention of Spousal Abuse

The hospital can play an important role in preventive efforts by promoting public awareness of family violence and encouraging preventive action by individuals and the community. The public should be informed of the facility's role as a community resource in combating domestic violence. The hospital can assist other community agencies to liaise effectively with health facilities. Brochures on the nature and consequences of spousal abuse and outlining available community resources can be displayed and distributed, and space can be provided for public forums. The hospital can also offer the services of staff for community committees.

It can be assumed that some hospital employees may be involved in a potential or actual abusive relationship. Programs to support staff with appropriate counseling should also be available.

Intervention with victims or abusers may result in a staff member experiencing extreme stress, frustration or feelings of inadequacy. Appropriate assistance through Occupational Health Services, peer support groups, counseling and other services should be provided in these circumstances.

Document Care Appropriately

Policies, procedures and protocols must clearly indicate what has to be documented and how. A checklist for developing such policies and procedures along with other sample checklists and guides, are included in the APPENDICES at the end of this publication, pages 91 to 99 and in the SAMPLE CHECKLIST and GUIDE at the end of this Section, pages 51 to 53.

The policies should include information regarding consents for treatment, referral, notification of police and photographs. Policies should also indicate what type of documentation is required concerning the objective data of the physical examination and the client's subjective account of the cause of injuries.

Appropriate forms should be provided for accurate documentation regarding identification, assessment, intervention and follow-up/ referral.

Collection and documentation of forensic evidence is a legal matter and should be carried out according to detailed protocols established by appropriate authorities. (Refer also to MEDICOLEGAL ISSUES, page 81.)

Evaluate the Program to Monitor and/or Improve Service Delivery

Quality assurance activities related to the spousal abuse initiatives should be linked with the overall quality assurance program of the facility. For further assistance in designing a quality assurance program, refer also to page 92, APPENDIX II - CHECKLIST FOR CARE AUDITS.

Evaluation criteria should focus on effective detection of abuse, comprehensive provision of services, coordination and

continuity of care, appropriate referrals, and appropriate and complete documentation with proper collection of evidence. Of immediate concern should be successful identification of abuse and transmission of information about the nature of the problem and existing alternatives to help the victim and the abuser.

Expected outcomes vary by service area and should be defined by the contribution of each area to the program. Although the ultimate outcome of care is a reduction in the incidence and prevalence of spousal abuse, health institutions contribute more in terms of interim outcomes, such as stabilizing the victim's situation or improving it sufficiently to justify termination of intervention by meeting the goals of the treatment/counseling plan, and/or by arranging appropriate follow-up/referrals. Client satisfaction is an important outcome criteria especially in terms of assessing the facility's sensitivity to victims' needs.

Support Research Efforts Related to Spousal Abuse

Health facilities should promote and assist in research projects related to spousal abuse. Of particular importance are research projects investigating the effectiveness of educational programs and services to clients, specifically those aimed at the prevention of domestic violence and intervention with victims and abusers. Many facilities may not be sponsoring primary research efforts, but they can contribute to the efforts of others by providing requested data.

3. PROGRAM GUIDELINES

3.1 Space Requirements

Patients who have been victims of any form of interpersonal violence will be emotionally upset, whether or not they show signs of trauma. They require privacy and a calm atmosphere wherever they are examined. Examination and counseling should be done in an appropriate area sensitive to the needs of the individual who has been abused.

3.2 Personnel Requirements

Due to the diversity and complexity of services required, the provision of victim services requires an interdisciplinary approach. Obviously, the variety of professional services available will

determine the scope of services to be provided. However, even a facility with limited resources can tap into other community-based services such as religious and volunteer organizations, police and legal services. When personnel and other resources are limited, another option is to interface with larger facilities in the region.

Refer to APPENDIX III - SUGGESTED ROLES FOR STAFF, page 94, for a list of possible task assignments for staff members. The roles outlined provide general guidelines only and should be individually adapted to each program.

Consultation and cooperation with other agencies will enhance the response to individual victims of spousal abuse and will facilitate the program's viability. Shared responsibility will likely minimize the risk of any one professional group or agency in the community being frustrated and overwhelmed in their attempt to meet all clients' needs.

A SAMPLE ASSESSMENT/INTERVENTION GUIDE FOR SPOUSAL ABUSE is included on page 52.

3.3 Planning and Direction - Policies, Procedures, Protocols

The Principles Underlying Involvement of Health Facilities (2.1) and the Recommended Program Objectives and Elements (2.2), pages 41 to 48, should be reflected in all policies, procedures and protocols.

Governing boards and management, as well as service providers, need to be sensitized to the problem of spousal abuse in their community and to the role their health facility plays in identifying and treating cases of spousal abuse. Health facilities should prepare policies and procedures for dealing with cases of spousal abuse which reflect their philosophy and preparedness to meet the needs of victims and abusers. A general POLICIES AND PROCEDURES CHECKLIST is included in APPENDIX I, page 91.

Institution-specific policies and procedures are needed to provide adequate direction and to identify appropriate lines of responsibility/authority. These should reflect an interdisciplinary response to cases when the client is the victim, as well as for when the client is the suspected or known abuser.

Policies and procedures should include references to:

- recognition of the problem of spousal abuse in society
- the institution's responsibility as a "helping" institution
- the interface between the institution and other agencies
- an interdisciplinary team approach
- the application of specific protocols, and
- the use of appropriate forms and documentation.

Not only emergency and social work departments, but all functional areas may require specific protocols which address their particular roles in identifying and treating cases of spousal abuse. Protocols should refer to identification, assessment, intervention, follow-up/referral and documentation issues.

SAMPLE CHECKLIST FOR EDUCATION PROGRAM ON SPOUSAL ABUSE

Orientation and continuing education programs for staff might include the following:

- Nature and consequences of spousal abuse
- History and sociological perspectives on spousal abuse
- Identification of myths, stereotyping, and personal biases
- Prevalence of problem
- Profile of the abuser
- Role of the health institution
- Identification of victims
- Nature of secondary victimization
- Assessment and intervention techniques
- Follow-up/referral resources
- Documentation requirements and forensic evidence
- Method of promoting communication with other service providers (police, emergency housing, social services, legal system and self-help groups), and
- Support services available to staff members.

SAMPLE ASSESSMENT/ INTERVENTION GUIDE FOR SPOUSAL ABUSE

When assessing cases of spousal abuse, health professionals should:

- Evaluate physical injuries and psychological manifestations
- Evaluate the need for complete sexual assault examination
- Obtain and document medical history
- Document and secure physical evidence for forensic purposes
- Review past records for previous history of abuse
- Establish precipitating factors resulting in present injuries and/or conditions
- Complete and document physical examination and psycho-social assessment, and
- Inquire about drug and alcohol use by victim and assailant.

Based on the index of suspicion, classify the case appropriately:

- No abuse suspected
- Abuse suspected but denied by client
- Abuse suspected and confirmed by client

If abuse is suspected but denied by client:

(1) In a caring nonjudgmental fashion, help the client acknowledge the role of violence as the cause of her health problems, and

(2) With the consent of the client, document the physical findings, perform a psycho-social assessment, and take photographs of the injuries (if possible).

If abuse is suspected and confirmed by client:

Intervene as detailed in (1) and (2) above and

(3) Carefully determine the seriousness of the problem by assessing not only the immediate level of injury but also the threat of future violence

(4) Validate the client's need and request for protection

(5) Assess the client's social support network and resources

(6) Determine degree of emergency - Note: the client's assessment of risk predominates

(7) Assess the level of violence in order to: provide assistance and protection for the victim and help for the abuser; help and protect any children present in the abusive environment; plan intervention to include psycho-social support and counseling; and access appropriate resources for future referral

(8) Determine if the victim's children are at risk and take appropriate protective action

(9) Determine whether the client wants to notify the police; with client's consent, help the client to contact the police, and

(10) Provide resource information for victim's immediate/future use.

INTERVENTION:

- The main objective of crisis intervention for victims is to provide information and support which enables them to initiate protective actions and follow-up. Support is based on the client's capacity for independent action, not on the immediate apparent dependence.
- The major thrust of crisis intervention for offenders is to encourage them to admit to the abusive pattern and involve them in treatment programs geared to resolving the violent behaviour. Health care professionals need to be aware that abusers do not usually seek help voluntarily; however, mandatory treatment by court order can be successful. Treatment should be independent of criminal proceedings.
- Both individual and family-centered counseling services can be effective for patients and families affected by spousal abuse.

■ SEXUAL ASSAULT[7]

1. INTRODUCTION

This Section discusses sexual assault of adults. All aspects of abuse/assault of children are discussed under Child Abuse.

It is crucial that health care providers perceive that sexual assault is a crime of violence, not a crime of passion motivated by sexual desire.

The misconception of the crime being one of passion has been perpetuated for years by religious and societal views, and is unfortunately still held by some members of society. The motivation of sexual assault is very complex but involves issues of hostility and control of one human over another.

1.1 Definitions

Sexual Assault

According to the criminal code, sexual assault is any form of assault involving some form of sexual activity. This includes kissing, fondling or sexual intercourse with another without their consent. There are three categories of sexual assault:

- Simple sexual assault — an assault which involves the use or threat of force
- Sexual assault causing bodily harm — an assault where any hurt to the health or comfort of the victim results, or where a weapon is used or the use of a weapon is threatened, and
- Aggravated sexual assault — an assault where the victim is maimed, disfigured or where the victim's life is threatened.

The legal issue is whether consent was given or not. The offender may or may not be known to the victim. The assault may occur between individuals of the same sex or opposite sex and the

7 See also MEDICOLEGAL ISSUES, page 81.

offender may be of either sex. Most frequently, the offender is male and the victim, female. For the convenience of reading the guidelines, the victim will be referred to as female and the offender as male.

In a health environment, professionals may see victims immediately after the assault has occurred (i.e. up to 48 hours), within a few days of the assault or months to years after the assault. This will depend on when the victim chooses to disclose the experience.

Many individuals are or have been in abusive relationships with a partner, parent or other person of authority, involving repeated unwanted sexual activity. With adult victims, each such event is a sexual assault — with children, sexual abuse. These individuals may also come to a health care facility immediately after being sexually assaulted, or they may choose to disclose ongoing or past situations involving repeated sexual assaults that they suffered as adults or as children.

Health facilities must be prepared to address the needs of all such victims. Because of the variety of circumstances under which victims may seek health services related to sexual assault, discussions in the sections on spousal abuse and elder abuse are also relevant to considerations of sexual assaults.

2. ROLE OF HEALTH PROFESSIONALS AND INSTITUTIONS IN RESPONSE TO SEXUAL ASSAULT

2.1 Meeting the Needs of Victims and Offenders

Health facilities and their personnel play an important role in the identification and treatment of sexual assault victims. A statement of philosophy based on the principles of rejection of violence in our society and a commitment to provide appropriate care is the basis for programming. Governing boards should endorse this commitment and ensure that well-designed programs and protocols are in place to respond to the needs of the victims, offenders and families, either directly by the facility or through collaborative networks of community services.

2.2 Disclosure of Sexual Assault

There are many barriers that prevent the victim from seeking help or pressing charges in instances of sexual assault. These include:

- Despite the changes in Canadian law in 1983 which improved victim protection and allowed the police to lay charges, the legal system can still be a difficult process for the victim to endure and can cause further victimization, thus discouraging her from pressing charges;
- The sentences given to offenders are often perceived to be light and good rehabilitation programs are not generally in effect in Canada; thus, the victim may be fearful for her safety when the offender is released and, as a result, does not proceed with legal action;
- There is often pressure on the victim from her family or friends not to press charges, seek help or disclose. This leaves the victim to cope without support or guidance from either professionals or family and friends;
- The individual may not seek help as she may be economically dependent on the offender, who may be an employer or a family member; and
- Problems of geography, language, physical or mental disability, age or cultural differences may isolate an individual victim.

2.3 Role of Professionals and Institutions after Disclosure

Hospitals must provide a coordinated response to the victim and the offender that will allow them to get the most help and support from the system. These guidelines are designed to assist facilities in meeting the needs of victims of sexual assault within the community, as well as the needs of the offenders. They will assist in developing an individualized protocol for the identification and management of victims and offenders.

The facility must provide prompt efficient service to the victim, ensuring good liaison with community resources, police and lawyers. Services must be provided in a non-judgmental, supportive manner that recognizes the victim's physical, emotional and legal needs. A caring, humane environment should be provided to prevent further victimization by the health care process.

Health professionals may also have to interact with offenders. They need to understand that victims and offenders can come from any background, socio-economic level, cultural or religious group. All are in need of treatment.

Ongoing education of the health professionals and other community members of the response network must continue, as well as the educational and informational support to the client.

It is important that the victim feels that she has control. All decisions such as pressing charges or having an examination are ultimately made by her, provided that she is competent at the time. Medical personnel must recognize this, but can play a role in explaining the pros and cons of the decision to be made.

The facility must understand its legal responsibility in responding to victims of sexual assault. Program protocols must take into account provincial legislation with regard to age of consent, informed consent, reporting, liability, gathering of evidence, transfer of evidence and documentation.

In considering the interface between the health and justice system, the victim's welfare and right to self-determination must always be given primary consideration. The prosecution of offenders is intended to support and protect the victim and reduce the incidence of the crime; thus, victims should be encouraged to press charges. However, the legal process can be difficult and personnel should be encouraged to be supportive and non-judgmental, whatever the victim's decision may be.

Differences Between Large and Small Communities

In the larger community, there may be several emergency facilities. A decision should be made, in coordination with provincial and local planning authorities, to identify one facility as the sexual assault centre of the community. This allows for development of a coordinated regional program involving all members of the sexual assault response team. The hospitals that do not have the designated emergency centre still need to develop protocols that allow for safe, efficient transfer of the victim who comes to their emergency department through self-referral. They also need to have guidelines for responding to the needs of in-patients and those of personnel.

There are several factors in the smaller community that must be taken into account when developing a program. Fears about lack of confidentiality may affect the victim's willingness to seek

treatment or disclose all details. The issues with regard to confidentiality are:

- The victim and/or offender may be known to several staff members, both professional and support, thus affecting the staff's ability to provide sensitive and non-judgmental service.
- The facility may treat all parties involved in the case including victim, offender and family.
- It may be difficult for victims or offenders to seek help if they personally know the staff and/or the community workers.
- The health professionals dealing with the case may fear for their own safety in a small community. This may affect their ability to give unbiased comprehensive care.
- Knowledge of the event and the victim's identity in the community may affect her ability to return to work, school or home due to embarrassment or fear.

These are just some of the issues of which hospitals in smaller communities must be aware. On some occasions, the victim's needs will be better served in another community and procedures for transfer should be included in protocols.

Other Considerations

Contact between the victim, supportive relatives or friends of the victim, the offender and various professionals and service providers, must be facilitated.

Service providers may include social workers, religious personnel, crisis intervenors[8], nurses, physicians, police, lawyers, self-help groups, mental health or counseling agencies. Resources that are available in the community should be identified and accessible to staff.

In the emergency situation it may not always be possible to begin a full forensic assessment of the sexual assault victim immediately. It is important, however, to plan to deal with her immediate physical and emotional needs. To ensure that she has support while waiting for the forensic examination, an appropriate staff member or community person should be identified to wait with the victim.

8 Crisis Intervenor: A person whose aim is to help restore the possibility of choice and a sense of direction to individuals caught in a crisis situation. This is done by offering an immediate response to a request for assistance, helping to reinterpret perceptions and providing emotional support, continuing contacts and advocacy.

Efforts to provide a prompt response should be made. The smaller community must identify which personnel will provide follow-up counseling and support (keeping in mind that the victim may be more comfortable if she is referred out of the community).

Support for the victim's family or significant others at the crisis stage and in follow-up counseling may be needed.

Research activity in the area of sexual assault is needed and health facilities should ensure that they provide support to research efforts.

The administration will need to consider funding resources available to them. Communities need to decide where ongoing follow up and treatment programs for the victim and abuser will occur, i.e. in the institution or in the community. Sources of funding (e.g. the Department of Health, Attorney-General, Social Services) should be identified.

3. PROGRAM GUIDELINES

3.1 Space Requirements

The centre that will provide immediate care to the sexual assault victim needs to be identified.

This emergency assessment area should have a quiet room away from the "mainstream traffic". This area should afford privacy where the victim and her support person can wait until the full assessment can be started. The examination itself should also be done in an area that affords privacy.

Shower facilities are not essential, but do permit the victim to wash after the examination; she may wish to do so, especially if she is going directly to the police station afterwards.

3.2 Personnel Requirements

An interdisciplinary approach to sexual assault/abuse should be used. Each profession has its own specific role and its own expertise. The roles should be clearly defined. The number of people involved depends on the size and scope of the program. To ensure a coordinated service, a committee of the key professionals involved

should be formed. The committee should meet regularly to facilitate, design and implement all aspects of the program.

The committee should include representation from professionals involved from within the hospital (e.g. nurses, physicians, administration, social workers, psychologists and appropriate religious personnel) as well as those involved in emergency counseling and follow up from the community (e.g. crisis intervenors, religious personnel, counseling agencies).

Before programs are designed, it is helpful to meet with representatives from the police department, crown attorney's office, forensic lab, and the facility's legal advisers to ensure that the victim's legal rights and the facility's legal requirements are being met. This team approach establishes definite lines of communication between the various professionals and ensures that the program runs efficiently.

The roles of the various people involved in the sexual assault program can be outlined generally. These would need to be adapted to each particular setting. Refer to APPENDIX III - SUGGESTED ROLES FOR STAFF, page 94 for a general guide to staff roles. In deploying personnel resources, the role and functions of the Sexual Assault Team also need to be considered as discussed under Policies and Procedures on page 91.

Staff Support

It is possible that staff may suffer from burnout if dealing with a number of cases, or that they may start to identify with the victims. This may affect their professional and personal lives. As well, there may be times when staff fear for their own safety. Thus, programs must be sensitive to individual staff needs. Coordinators must be aware of the need for staff to express, share and discuss their feelings and, at times, to take a leave from working with sexual assault victims. A regular group meeting of staff that work closely with the victims can be helpful in providing staff support. The staff should know how they can obtain counseling for themselves if needed.

Staff members experiencing difficulty in helping with sexual assault cases due to personal biases or experiences should be encouraged to get help. If the attitudes are deemed to be detrimental to clients, those staff members should not be part of the sexual assault team until they have resolved their own difficulties.

3.3 Planning & Direction - Policies, Procedures, and Protocols

Specific policies, procedures and protocols that meet provincial legislative and medical requirements must be developed. These protocols should meet the needs of the victims, institution and community. As previously mentioned, protocols should be developed by an interdisciplinary committee that meets regularly to ensure ongoing surveillance and upgrading of the program.

Purpose

The purpose and justification of the program must be clearly stated. The protocols should provide an efficient, coordinated response that meets the emotional and physical needs of the sexual assault victim and legal requirements of the system.

Identification

It is important that protocols are developed to address the different routes by which the victim may contact the health facility. She may come through the emergency department and may be either self-referred, referred by a community counseling agency or be brought in by the police. She may be attending an ambulatory care clinic and may disclose the assault to a professional in that setting. She may be an in-patient choosing to disclose at that time. The departments, units and personnel that are responsible for carrying out the screening, assessment and referral process in the facility should be clearly identified.

Reporting

The legal reporting requirements should be clearly outlined, including who does the reporting, to whom and in what manner.

Consent

The procedure for obtaining informed consent and the meaning of this consent should be outlined clearly and understood by all personnel involved. Decisions as to what care and treatment will be received must be made by the victim, i.e. to receive medical treatment only, or to have a full forensic exam. The law with regard to age of consent and consent of a mentally incompetent adult should be defined clearly for all personnel. Review of all consent forms by the facility's legal advisor will ensure that they are acceptable and

protective. The victim is in a traumatized state and time is needed to explain all aspects of the medical and forensic examinations. The consent should be obtained by a well-informed individual.

Sexual Assault Team

Response to sexual assault requires a coordinated, interdisciplinary approach, and if possible the formation of a sexual assault team should be considered. All members of the team should be identified with their roles clearly outlined. All institutional and community-based resources should be defined.

In smaller facilities, total management of the victim by the facility may not be appropriate due to lack of sufficient personnel, lack of specialized personnel, problems with confidentiality or difficulty in providing unbiased care. In these instances, policies and procedures must be established that will allow initial crisis management, including initial assessment, stabilization and discharge planning to an appropriate agency with the appropriate resources.

In identifying members of the team and available resources, the planners must keep in mind that these victims require emotional support and that the examination may require a significant amount of time. Flexibility and innovation are important criteria in identifying team members. For example, after an initial prompt triage and attention to the victim's immediate physical and emotional needs, the victim may have to wait in the emergency department until the forensic examination can begin. She should have a supportive person to wait with her and/or her family, friends, etc. This person could be a nurse from the emergency department, or from another unit if an emergency department nurse is unavailable, a volunteer from the hospital or the community, a social worker, or an appropriate religious representative. All of these individuals will need to have received specific training.

Physician time can be substantial and, if the emergency department is busy, then the ability to provide prompt uninterrupted medical time to the victim is limited. The use of nurses trained to assist in the collection of forensic evidence can considerably reduce the physician's time and still not jeopardize the quality of care. Consideration should be given to training a roster of community physicians who would be on call to the sexual assault program. At the least, back-up physicians should be on call to the emergency department to allow one physician to spend the required time with the victim.

If possible, physicians of both sexes should be trained and available; for some victims, the sex of the examiner may be extremely important and may affect her willingness to be examined.

Sexual Assault Kits

Some provinces have standard kits that can be used directly or adapted to the needs of the hospital or the victim. These kits include forms, containers, labels, etc. which make the procedure easier. In many areas, the R.C.M.P. or other authorities may provide the sexual assault kits; however, if these are not available, the hospital should assemble its own kit ahead of time and include this task in the protocol. Materials needed for the examination should also be assembled ahead of time.

Care and Treatment

The protocol for the care and treatment of the sexual assault victim should clearly outline all aspects of the examination, that is identification, assessment, documentation and management. As part of the documentation, photographs may be needed and centres should identify the person best qualified to do this. Ideally, the photographs would be taken at the time the victim is being examined to avoid the need for her to undress again at the police station.

It is important that the medical staff are aware that the victim's medical management takes priority over forensic specimen collecting.

The specimens must be collected and transferred in a way that maintains the legal chain of evidence.

Documentation

The data must be documented in a clear, concise and complete manner. If forms are used as part of a standard sexual assault kit, they must be approved by appropriate hospital authorities and be sufficiently clear to be useful in court.

Confidentiality

The victim's consent must be obtained before information is released to the police, medical staff or the family doctor.

The interview and examination should be conducted in an area that offers privacy. Policies should be established with regard to releasing medical records to other areas of the hospital, i.e., this information may need to be kept separate from the general medical record in order to ensure confidentiality.

Disposition, Follow Up and Community Interface

Follow up of the victim must be arranged with the family doctor, the ambulatory care department or other services, depending on the victim's wishes and the situation. Community resources should be identified and involved in discharge planning where appropriate. It is imperative that the victim's safety be assured.

Refer also to Page 91, APPENDIX I - POLICIES AND PROCEDURES CHECKLIST for a general guide in developing program policies and procedures.

3.4 Evaluation

Ongoing quality assurance activities should occur to ensure that the program is meeting its objectives and providing prompt, efficient and coordinated service to the victim and offender. Quality assurance activities may include individual case reviews, audits and research activities. Evaluation of institutional, community out-reach and follow-up programs would all be appropriate.

Refer also to page 92, APPENDIX II - CHECKLIST FOR CARE AUDITS for assistance in planning Evaluation and Quality Assurance.

3.5 Prevention

Health Facilities as Community Facilitator/Resource

Hospitals can be a community facilitator/resource in many ways; for example, they can

- Play a role in educating the public and community health staff, (for example, physicians, public health nurses, social workers, psychologists) through public seminars, seminars in the schools and by producing information brochures, posters for waiting rooms, advertising services on television, radio and in newspapers;
- Participate in the community response to sexual assault;

- Develop ambulatory care counseling and treatment service for victims, families and offenders; and
- Establish self-help victim groups, train personnel to facilitate these groups or provide the physical space for community-run groups.

Employee Assistance Program

All employees (not just health care staff) should be made aware that counseling is available for victims of assault/abuse. Some employees may be or have been victims of assault/abuse and may not have received counseling.

Support of the health professionals is important, particularly with respect to prevention of burnout. Confidential counseling should be available for members of the health care team who identify the need.

Patient Advocacy

The primary goal of sexual assault programs is to provide excellent service to the victim. It is important that efforts to help the victim do not place her at further risk. In certain situations, admission could be considered if appropriate. Hospitals have a moral obligation to provide safety to the victim and any others who may be at risk.

The public should be made aware that the hospital has a positive attitude toward dealing with the victim and perpetrators of adult sexual assault. The hospital should stress a caring, comprehensive, confidential and non-judgmental approach.

The board of trustees is in a position to advocate to governments for funding to support treatment and counseling programs for perpetrators and victims.

The court process is very stressful for the victim and can be for staff. Health facilities may play a role in supporting organizations or groups that advocate that cases be processed quickly, efficiently and in a manner that offers the least trauma to the victim.

3.6 Education

The professionals involved in providing care to the victims need ongoing training and education. This training should focus on

helping the victim who comes immediately after the sexual assault and the victim who discloses the sexual assault that occurred in the past. The facility should also provide training on how to respond to the perpetrator.

Training may be provided through ongoing in-service, continuing education and sending key personnel to obtain training at more experienced centres. Professionals outside the facility (e.g. police, lawyers, religious personnel, community workers) should also receive education with regard to the medical examination, the emotional impact on the victim, and the facility's protocol. This education may be provided by hospital personnel.

Professional training should include legal aspects of the sexual assault examination, i.e. specimen collection, documentation, and transfer of evidence. As well, preparation for court appearance should occur, i.e. how to prepare a curriculum vitae, how to give evidence in court, and the importance of the discussion of the case with the prosecutor.

Client education should also occur. Clients should be made aware of what to expect with regard to the medical and legal proceedings. They should be made aware of what resources are available in the facility and in the community. A variety of individuals may be providing this information to the victim, including nurses, social workers, crisis intervenors, physicians, and police; thus, the information must be accurate and consistent. Brochures and other client education materials can be helpful.

Appropriate training to both undergraduate and graduate professionals could include practical, supervised case assessment, seminars, and in-service education. The professionals would include physicians, nurses, lawyers, social workers, psychologists, police, teachers, crisis intervenors and appropriate religious personnel.

3.7 Research

Research activity in the area of sexual assault is needed and should be supported. Even in the absence of on-site research activities, accurate reporting and complete documentation will facilitate research projects at a later date, or contribute to research being carried out by others.

■ ABUSE OF THE ELDERLY, FRAIL OR VULNERABLE ADULT[9]

1. INTRODUCTION

This section has been prepared by a team providing care primarily to elderly, frail or vulnerable adults. Facilities providing care to the mentally or physically frail in other age groups should modify the approaches suggested to their specific program needs.

The process of aging is complex, demanding and not always understood. The vulnerability and physical or mental frailty found to varying degrees among some older adults is very different from that of the patient in a hospital who is temporarily dependent on medical personnel and caregivers who may value this dependence. Seniors need, above all, respect for the gradual evolution of their aging, along with the assurance of the optimal use of their capacities - physical, psychological and social - and more particularly of their mobility, autonomy and responsibility for themselves.

Some older adults are among the most vulnerable members of society, both physically and emotionally. Lack of knowledge of their rights is common among seniors. Their prior experiences and their social and religious milieus have often conditioned them to submission, fear and resignation. More specifically, the frail elderly are often unable to protect themselves and are often unable or unwilling to admit to abuse particularly when it is done by a caregiver. They may choose, moreover, to remain silent because of fear of abandonment, reprisal, institutionalization or because of a desire to avoid embarrassment and shame.

Caregivers must remain sensitive to these realities and to their own responses to them. To care for the elderly is also to confront one's own aging process, to make adjustments in attitudes and behaviours. These adjustments may require a great deal of energy, and caregivers may find it difficult to maintain their perspective while meeting the needs of the elderly.

9 See also MEDICOLEGAL issues, page 81.

Because of the particular needs of the elderly, frail, or vulnerable adult, this section considers cases in which ill-treatment occurs in the community or home and is identified or disclosed while in care, as well as instances of abuse that occur within facilities such as hospitals or long term care facilities. Most of the discussion applies to all settings with some comments addressed specifically to abuse occurring in an institutional setting.

1.1 Statement of Philosophy

The Report of the Second Canadian Conference on Aging 1983, contains the following statement of philosophy in respect to the aged:

"All Canadians, including the elderly, have the right to peace and order and good government, and that consequently it is incumbent on the different levels of government and on Canadian society in general to take positive and preventive measures to assume the well-being of those elderly as a whole as well as of those in specialized centres, free from all anxiety or acts of violence that could threaten their physical or mental well-being and the full enjoyment of their possessions."

1.2 Definitions

The phenomenon of elder abuse is not well understood in our society. There are as many definitions as there are authors. For the purposes of these guidelines the following definitions take into account mistreatment and neglect of the elderly. They include acts of commission or omission that result in harm to the elderly - physical, sexual, psychological and financial abuse.

Physical Abuse

Cruelty occurs in situations where there are acts of violence, rough treatment causing injury or physical discomfort, or gross negligence, such as ignoring the need for help, withholding the necessities of life (for example, food) or failing to provide for housekeeping, personal hygiene or medical needs.

Psychological Abuse

Psychological abuse includes confinement, isolation, inadequate care (insufficient time, attention or understanding of needs), and the suppression of active participation in life. This category also includes verbal and emotional abuse leading to humiliation,

intimidation, deprivation of rights or infantilization, or any other treatment which may diminish the sense of identity, dignity and self-worth.

Financial Abuse

Financial abuse includes such financial exploitation as withholding money, fraud, theft, wrongful appropriation or misuse of money, possessions and property. Financial abuse also occurs in situations in which the means for obtaining daily necessities are withheld.

Sexual Abuse

Sexual abuse includes sexual assault, molestation, sexual harassment or attempts at the above.

1.3 Profile of Victims and Abusers

Victims are most often the elderly over 75 years of age, in poor health and with physical or mental disabilities; incapable of attending to their own needs and protecting themselves; and, living with those who are mistreating them. They may well be aware that they are in an abusive situation but frequently are reluctant or unwilling to indicate that they are being mistreated.

Abusers, for the most part, are either the spouse, an adult child or relatives without direct parental links with the victim. In the institutional setting, the abuser may be a co-resident, relative, visitor or staff member.

1.4 Factors Contributing to Abuse, Assault, Neglect and Violence Against the Elderly, Frail or Vulnerable Adult

The social problem of domestic violence, particularly violence against the elderly, frail or vulnerable adult, has deep ramifications with regard to our societal values and reflects the malaise of our society. In most provinces in Canada the legislative framework and other structures to facilitate intervention, information and protective programs are in a process of evolution.

Many broad socio-environmental factors as well as individual and family factors contribute to violence against older adults or the frail/vulnerable adult.

A society which increasingly rewards competition and productivity falls easily into devaluing its senior, frail or vulnerable adults. The violence which is omnipresent in our society and widely reflected in the media is, in essence, the exertion of power by the powerful over the vulnerable for personal advantage.

The underlying stresses of human relationships in the family, the workplace and in social life can foster intolerance, impatience and, eventually, violence. Poverty, which is the lot of a great number of families and, more particularly, of a very great number of the older adults, places additional stress on human relationships.

Alcoholism and drug use, which exacerbate violent behaviour and negligence, often serve as an excuse for and an escape from responsibility for wrong-doing from the perspective of the both the family and other health professions.

Changing familial values and roles often makes it difficult for family members to take responsibility for themselves, let alone those who might be dependent on them.

Similar social and personal tensions may be found in health facilities. They can be aggravated by inadequate financial and human resources, lack of education, uncertain guidelines, poorly-defined values, inadequate coordination among programs or a manager caught up in the complexities of the system.

The hospital model, frequently replicated in senior citizen long-term care facilities, can hamper realization of the most appropriate lifestyle for dependent adults. Conditions for daily living are often inadequate, sometimes critically so, in terms of the lack of privacy, space and appropriate accommodation for the residents, and the lack of respite services and resources for the caregivers. The caregiver may face responsibilities that are too heavy, leading to exhaustion and burn-out. They may work in isolation and be unaware of available community services.

In both the community and the institution, inadequate knowledge and skills can lead to breakdowns in communication and a failure to appreciate their reality.

Earlier inter-generational or sibling personality conflicts can seriously affect the capacity of a caregiver to respond to the needs of a family member who becomes dependent later in life. Also, in the family environment, it is not uncommon to find elderly or frail

caregivers providing care for another elderly person less independent than themselves.

Circumstances deteriorate in some instances due to the failure of the various health and welfare systems to deliver services appropriate to the needs of seniors.

2. ROLE OF HEALTH FACILITIES IN RESPONSE TO ABUSE OF THE ELDERLY, FRAIL OR VULNERABLE ADULT

Health facilities play an important role in the identification and treatment of elderly, frail or vulnerable victims. Each health facility should ensure that appropriate policies, procedures and protocols are in place to support and guide the delivery of services to the victims and, where required, the abusers.

2.1 Principles Underlying Involvement of Health Facilities

The broad spectrum of contributing factors in abuse of the elderly, frail or vulnerable adult have been discussed in some depth. Intervention programs must contribute to solutions and be guided by compassion and understanding. To the greatest extent possible, as with all other types of victimization, clients should be assisted to regain an optimal level of self-respect and control over their lives and to participate in any decisions affecting them.

Each health facility should look at its own community needs in order to determine how it can best serve the needs of seniors and frail or vulnerable adults within that community. Facilities should promote communication among the health facility, provincial adult protection services, police, justice and public health systems as well as any self help groups and community-based programs which might be available. The facility should consider its role in education about abuse of the elderly, frail or vulnerable adult for its own personnel, community professionals and the lay public. It should also consider its role in conducting research and assisting in its application.

The governing board should include in the mission statement its support of programs that are developed.

2.2 Recommended Program Objectives and Elements

A plan for the development of effective early detection, preventive and intervention measures should include:

- Educated staff with a working knowledge of factors which suggest abuse, such as injuries that are inconsistent with the cause given, bruises, medications that are inappropriate to the condition, resignation, withdrawal, passivity, or other unexplained behavioural changes;
- Treatment and counseling services to help the dependent adult cope with the situation in the least restrictive way possible;
- Removal of the victim from the abusive situation according to provincial legislation where appropriate and where no other acceptable option exists;
- In the case of an identified abusive employee, counseling such an individual and documenting the facts involved in the incident and in the review process; implementation of an appropriate corrective process and identification of the reporting procedure; and
- Collaborative and co-operative interdisciplinary team effort in identifying, assessing, treating and preventing further abuse.

Differences Between Large and Small Communities

For further discussion of some of the issues to be considered in planning for small communities refer to the Sexual Assault section, page 57.

Protocols are required to facilitate efficient responses to the person who has been or is suspected of being abused. There are several factors which must be taken into account when developing a service in a small community. Fear about lack of confidentiality may affect the victim's willingness to seek treatment or to disclose all details.

Identification of Abuse within the Institution

For the most part, abuse of dependent adults occurs within the victim's own home or community. However, abuse may also take place within health facilities. Abuse of this kind may involve the impact of care on the patient, both physically and mentally. All interventions or treatment plans for the patient need to be clearly defined as being for the benefit of the patient. From this perspective, the

following may constitute abuse of the older frail or vulnerable adult:

- administration of inappropriate or excessive medication causing drowsiness, confusion and immobility, resulting in an attitude of dependence and the premature loss of the capacity to cope with life
- inappropriate chemical or physical restraint
- unwarranted resuscitative efforts or other aggressive modes of therapy which do not take into account all of the factors involved
- deprivation of treatment, care or medication, or the basic needs of the individual
- failure to coordinate a care plan which reflects the needs of the patient or resident with the services available
- lack of training and orientation, improper personnel selection, to meet the needs of this specific group, and
- verbal abuse.

Early Identification and Prevention

No setting serving the older or frail adult is untouched by the possibility of such abuses, so it is important to be aware of the signs or symptoms which might cause suspicion of abusive treatment.

A plan for effective preventive and early detection measures should be established, explained to all personnel and implemented by each caregiver. The implementation and execution of the action plan, including training, should be entrusted to a staff member who enjoys the confidence of the staff. Staff should make every effort to obtain the confidence of victims so that they may overcome their fears and disclose. All personnel should be sensitised to the likelihood of abuse.

With respect to abuse within a facility, programs must be put in place to:

- monitor patients or residents and their care, and identify abusive situations
- provide staff education and preventive measures
- manage the problem once identified, and
- rehabilitate staff involved.

Resources

Communities often have a number of supportive resources that help in early detection or intervention, such as services focussed on prevention, advocacy, support, education, lodging information, respite care, temporary shelter, legal, financial, psychological or spiritual counseling services. Services that may assist in enabling older or frail adults to function as independently as possible include:

- services for keeping in touch, such as the media, radio, TV, newspapers, magazines directed towards seniors
- senior citizen centres, activities and educational programs for older adults and for those who look after them
- specialized services of the police and at banks
- transition houses, emergency homes
- respite care
- appropriate religious personnel
- centres for the promotion of the rights of seniors
- volunteer recreational services, and
- visitors in homes and institutions.

3. PROGRAM GUIDELINES

3.1 Personnel Requirements

Refer to APPENDIX III - SUGGESTED ROLES FOR STAFF, page 94 for a general listing of possible task assignments for members of interdisciplinary teams, keeping in mind that this material provides general assistance only and needs to be adapted to each individual program.

An interdisciplinary approach to the victim should be developed, explained to all personnel and implemented by each caregiver. With such an approach, each profession has its own specific and important role and its own expertise. Staff should make every effort to obtain the confidence of the apprehensive victim, so that they may overcome their fear and disclose their abuse and their abuser. All personnel should be sensitized to the likelihood of abuse. They should be knowledgeable of their own roles, and those of other staff involved in dealing with it.

3.2 Planning & Direction - Policies, Procedures, Protocols

Each health facility should develop its own policies, procedures and protocols in the following areas for the management of cases of abuse. A general Policies and Procedures Checklist is included in APPENDIX I.

Purpose

The purpose of management of abuse including early identification, intervention, protection and treatment must be clearly stated.

Identification

Early identification leads to early intervention and could prevent secondary victimization. Victims may come themselves to the emergency or ambulatory care departments or be referred by a community counseling agency. Since cases may be identified in a number of ways, there should be a procedure in place to allow follow through regardless of where they are first identified.

Duty to Report

Adult protection legislation in some provinces clearly states the duty to report all cases of abuse involving older, frail or vulnerable adults. This area of concern is in a process of change; policy should be current and reflect appropriate provincial legislation. Policy should also state clearly the

- mechanism for reporting;
- staff person responsible for reporting;
- mandate/office to be notified.

Consent

The procedure for obtaining informed (surrogate) consent and the meaning of this consent should be outlined clearly and understood by all personnel involved. The victim can decide what treatment is acceptable. In some situations it may be necessary to obtain qualified advice with respect to the mental competency of the victim. The consent should be obtained by a well-informed individual. The law with regard to consent of a mentally incompetent adult should be clearly defined for all personnel and determinations of incompetence should be made by appropriate professional staff. All consent forms

and consent procedures used should be reviewed by legal advisers to ensure that they are acceptable and protective.

Institutions should have a process in place by which a senior administrator and/or ethicist could be available for consultation within a region to provide advice relative to complex situations regarding the determination of competency and the validity of informed consent. Effective regional expertise in this area is usually available.

Separate guidelines covering PSYCHOGERIATRIC SERVICES, scheduled for publication in 1989, will provide a more definitive review of the issue of consent.

Assault/Abuse Team

A team could be identified with clearly defined roles with respect to assault/abuse of the elderly, frail or vulnerable adult. In larger facilities this may be a separate team; or this type of abuse might be combined with other issues of assault and abuse. In long-term care and home care services, such a team could be coordinated in their in-service training department, for example.

Regardless of composition of the team, its resources within the facility and the community need to be clearly defined. There may be a situation where total management of the victim by the facility would not be appropriate due to lack of sufficient personnel, lack of specialized personnel, problems with confidentiality or difficulty in providing unbiased services. In such instances, a policy that will allow initial crisis management, including initial assessment, stabilization and discharge planning to an appropriate agency with the appropriate resources, must be established.

Care and Treatment

The protocol should clearly outline all aspects of the examination, i.e., identification, assessment, documentation, management and follow-up. As part of the documentation, photographs may be needed and centres should identify the person best qualified to do this. Ideally the photographs would be taken at the time the victim is being examined to avoid the need to undress again at the police station.

It is important that the medical staff are aware that the victim's medical management takes priority over forensic collecting. The

specimens must be collected and transferred in a way that maintains the legal chain of evidence.

Records

It should be clearly stated that data must be clear, concise, accurate and complete.

Confidentiality

Consent of the victim or informed consent must be obtained before information is released to police, medical staff, family doctors or any other appropriate authority.

Disposition, Follow-up and Community Interface

Follow-up after discharge must be arranged depending on the victim's wishes and the details involved. Community resources should be identified and involved in discharge planning where appropriate.

3.3 Evaluation

There must be an evaluation program in place to ensure that these cases are being addressed promptly, efficiently and compassionately. These ongoing quality assurance activities may include individual case reviews, audit and research activities. Evaluation of institutional, community out-reach and follow-up programs would all be appropriate.

Refer also to page 92, APPENDIX II - CHECKLIST FOR CARE AUDITS, for assistance in planning evaluation and quality assurance.

3.4 Prevention

Health facilities should assume a facilitator role and act as a resource service in the prevention process by:

- educating the public and the community health staff and participating in the community response to these concerns, and
- providing counseling and treatment services to victims, families and other individuals involved through the ambulatory care department.

3.5 Education

Personnel involved in the care and treatment of the older, frail or vulnerable victim need ongoing training and education. The training should include sessions and seminars that focus on the dynamics of this type of abuse, as well as risk factors and possible treatment strategies. Seasoned practitioners should also consider training others in their communities in order to develop cohesiveness among the various agencies that deal with older, frail or vulnerable adults. This would lend credibility to the issue of abuse and neglect among these groups.

Consideration should be given to the need to provide training to undergraduate and graduate professionals. This training could include practical supervised case assessments, seminars and in-services. The professionals would include physicians, nurses, lawyers, social workers, psychologists, police, crisis intervenors and religious personnel.

3.6 Research

Health institutions should promote research into the causes of abuse and neglect of the elderly, frail or vulnerable adult. The profiles of victim and abuser must be more closely identified. Research is also needed into the types of abuse and the frequency with which these persons are institutionalized as a result of abuse or neglect. To facilitate ongoing or future research, reporting must be accurate and documentation complete.

All research involving seniors must follow established legal and ethical procedures for research involving human subjects, with particular respect for the importance of informed consent by the senior or frail adult.

■ MEDICOLEGAL ISSUES

This section deals with a number of important areas involving not only the medicolegal aspects of the management of abuse, assault, neglect and family violence, but also certain forensic sciences aspects of these concerns.

In general, all programs should be developed in accordance with provincial legislation and in collaboration with provincial and local justice and law enforcement authorities. All policies and procedures relating to medicolegal issues should be reviewed by the facility's legal advisor.

Consent

Informed consent must be obtained in any case where information obtained during medical examination is to be used later in evidence.

In medical practice, consent is usually obtained in two forms: a) implied consent; b) expressed consent. Implied consent is usually the form of consent that is in effect when patients by their very presence in hospital indicate consent to treatment. This form of consent is insufficient for the type of medicolegal case likely to be the subject of criminal or civil litigation.

Expressed consent may be either verbal or written and in all cases of medicolegal examination written consent is strongly advised. It is most important that this consent should be "informed consent." This means that the person being examined should not only understand the nature of the examination but the nature of the consequence of this examination, including who will be provided with the results of the examination and whether or not this information will be used subsequently as evidence. This consent should be signed by the victim and persons conducting the medical examination and should be witnessed by someone independent of the police. In many instances, this consent may have to be provided by the legal guardian or significant others.

Documentation of Findings

Complete and legible records of medical examination and evidence collecting must be made in each case. The date and time of examination together with the names of all those present should be recorded. A complete history should be taken to include any information which may have assisted the examiner in determining the nature and extent of the examination. All injuries should be documented fully and a complete record of all evidence collected should be included in the health record.

Where possible and appropriate, a photographic record of the victim and injuries should be made and should be included in the medical file.

Handling and Preservation of Evidence

Any material related to a potentially criminal case may be required for examination at a forensic science laboratory. This material may include clothing, weapons, bullets and samples of body fluids. The purpose of these examinations is to determine if a known and an unknown sample had a common origin, and the handling of these samples must be conducted in such a way that they are kept free from contamination.

It is the responsibility of any individual who has possession of these samples to ensure that they are properly identified, preserved and packaged for transportation. Failure to do this may result in loss or deterioration of the sample. An inability to prove continuity of the sample may result in its inadmissability as evidence in court.

Each item must be separately identified in such a way that this marking does not interfere with or destroy the evidence to be examined. If it is not possible to mark the items directly they must be placed in appropriate containers and each container marked for identification.

Every effort must be made to preserve the object in the condition in which it was found. To prevent decomposition, items which are stained with blood or other body fluids need special handling. Wherever possible, they should be air dried prior to packaging; otherwise they should be packaged in a paper bag and transferred as soon as possible. Blood samples and samples of organs should be refrigerated.

Items of clothing should always be packaged individually in plastic or paper containers. Each item or container should be labelled with the following information if appropriate:

(a) what the item is,

(b) where it was found,

(c) when it was found,

(d) who found it,

(e) how the item was recovered, (eg. during surgical operation)

The initials or signatures of all persons who have had custody of the item should be placed on the label.

When the samples are handed over to a police officer or other officer of the court a record of the name of the person to whom the exhibits are handed must be maintained by the health facility, together with the date and time that this exhibit was handed over.

Records of all of the procedures involving the handling of exhibits in relation to any particular victim should be placed as a permanent record on the medical file in such a way that it can be easily retrieved.

Procedures manuals are available from all R.C.M.P. forensic science laboratories, and from the provincial forensic science laboratories in Toronto and Montreal. From time to time procedures relating to handling of evidence will be changed as laboratory methodology changes. It is important that an up-to-date manual for the handling of such evidence be available.

In most provinces, special kits are available for certain types of medicolegal examinations, eg. sexual assault kits. Information about these kits can be obtained directly from the forensic science laboratories in any particular jurisdiction.

Provision must be made for the preservation of material that may later be required for medicolegal purposes.

Access to Medical Records and Reports

Clear instructions must be available for staff as to the procedures for release of medical records and reports. These instructions

should be developed in accordance with provincial legislation and in consultation with the institution's legal adviser.

In general, normal procedures for the protection of confidentiality of medical records and for obtaining informed consent for the release of information apply equally in these situations, with two important exceptions:

- where reporting of suspected abuse or assault is required by provincial legislation, such as the child protection legislation of all provinces and the elder abuse reporting legislation in some provinces; and
- where specifically demanded by court order or warrant.

Notification to Coroners and Medical Examiners

Requirements for the notification of cases to coroner and medical examiners varies considerably from one province to another and may be modified from time to time, so it is important to establish protocols consistent with the current provincial legislation.

In all jurisdictions, deaths from abuse, assault, neglect or domestic violence are notifiable.

Duty to Notify Provincial Authorities in Non-Fatal Cases

The duty to intervene where abuse is suspected is no longer just a moral duty. Notification is required in all provinces for suspected child abuse, and in a growing number of provinces for elder abuse or abuse of the frail/vulnerable adult. Instructions for reporting in non-fatal cases of abuse must be developed in consultation with the legal advisers and provincial protection authorities. Consultation with local law enforcement officials in the preparation of these instructions is also helpful in maintaining clear and collaborative relationships. All policies and procedures must be kept current with respect to provincial legislation on this issue.

The Procurement of Human Organs and Tissues from the Bodies of Victims of Abuse, Assault and Neglect

Victims of criminal assault who have been certified as brain dead may be appropriate donors for organ transplantation purposes.

No standard procedure exists in Canada relating to which particular types of cases are suitable for organ donation.

Provincial policies on these matters are undergoing rapid change, however, in all provinces the coroner or medical examiner must be notified prior to selection for possible donor purposes.

Preparation of Opinions and Reports

Medicolegal reports generated as result of the examination of victims (or suspected victims) may take two forms:

1) A factual report based simply on the observations documented during the examination and care of the victim;

2) Opinion reports based on conclusions of an expert in the area. These latter may involve expert opinions not only on observations and records taken by the report writer, but also on information obtained by other parties involved in caring for the victim.

In many cases there may be a combination of statements of fact and statements of opinion. It is most important that opinion reports include information on the qualifications that establish the expertise of the individual. These opinion reports should also include a complete list of all of the documents and sources of information on which the opinion is based. Medicolegal report writing requires training in skills not always found in health professionals. Information about such report writing should be included in the in-service training program.

Training

Medicolegal training programs should be an essential part of all in-service training programs related to abuse, assault, neglect and family violence and should be geared to all health care workers and trainees regardless of discipline. Standard curricula should be prepared and these should include the documentation of injuries, recording of the history given of the injuries, correlation between the history and the actual injuries, the handling of evidence, guidance on report writing, court deportment and presentation. Where necessary, these training programs should be supported by a basic forensic medicine handbook.

■ CONCLUSION

Interdisciplinary and intersectoral cooperation and coordination are essential to effective intervention in cases of abuse, assault, neglect and family violence. A number of important strategies and structures can facilitate this collaborative interaction.

Smaller institutions may support and encourage staff with effective policies, procedures and referral mechanisms to enhance cooperative or team approaches. Frequently, the quality of care and the effective use of staff is improved by a variety of structured approaches, which may include committee structures, the use of interdisciplinary teams dedicated to these problems, and planned arrangements to coordinate the relationships with the various community services.

Committee Structures

As coordinating mechanisms, a variety of committee structures or functions may be useful for both the planning and implementation phases. The purpose of such committees should be clearly defined, with membership appropriate to this purpose. The development of policies, procedures and protocols, the maintenance of ongoing community liaison, the promotion of an interdisciplinary team approach to case management, support for educational and research efforts, and advice/assistance in evaluation of programs and overall community response are but some of the functions which may need to be incorporated into committee structures.

In general, goals of the committee should focus on the establishment of clear and accessible policies and procedures, a network of informed personnel and a climate which enables all staff members to function professionally when faced with the problems of abuse or violence. Committees must resist becoming islands of expertise isolated from the regular staffing complement of the facility. In the final analysis, the quality of service may well be put to its most severe test on an evening shift of a holiday weekend.

Groups with a defined mandate to consider certain aspects of a situation may be more effective than efforts to integrate all functions into one very broad interdisciplinary advisory committee structure.

For example, if specific case management is considered at a committee level, the coordinating committee members required at the initial stage of identification, reporting, documentation and referral to protective and justice systems may be somewhat different from those required for ongoing case management and follow-up referrals.

In all situations, the composition of such committee structures will depend on the size of the facility and the scope of the program. Mechanisms for addressing various aspects of these concerns have been included in the specific sections of these guidelines.

Interface with Community Services

At the direct service level, during the assessment and intervention phases, communication with relevant agencies such as child welfare, public/community health, schools, police and legal services may be required to ensure protection for the victim, gather collateral information and/or assist in comprehensive planning.

Whether the victim is returning home or requires alternative living arrangements, staff will need to make many contacts with a number of community resources in anticipation of discharge, in order to encourage development of an informed community-based support network. These contacts may include transition houses, resources for financial support or advocacy, individual or family counseling and other specialized services where appropriate. Detailed references to appropriate services have been provided in the individual guidelines.

To complement and complete the direct service functions of identification and treatment of the abused, support to the victim's family and intervention with abusers, some facilities may assume additional roles in abusive situations, and may need to assume total management of referrals and coordination in some circumstances. In other situations, community services at the provincial or local level may work within the health facility in the assessment and management of protection aspects. At several levels, community coordination is essential. The expectations and protocols for such interface should be established formally, clearly designating the roles and responsibilities of each professional or agency.

Other appropriate tasks include community consciousness-raising, via the media, to inform the public about resources for prevention or intervention. To meet the needs of the victims themselves, pamphlets and brochures detailing self-protective precautions and

available crisis resources should be distributed to strategic locations throughout the health facility.

Interdisciplinary approach

When dealing with abuse, assault, neglect and family violence, there is a phase of development during which the various disciplines need to share their interests, feelings, attitudes and needs to achieve a better understanding of the scope and ramifications of the problem and the requirements of the program. This process, which appears slow and unproductive at first glance, is essential, constructive and ultimately very effective in the development of well-functioning team approach.

Interdisciplinary teams dedicated to abuse\assault programs need to address the issue of the abuse of power not only to fully understand the nature of intimidation and victimization but, equally, as an important aspect of the interdisciplinary process itself.

Health facilities will be challenged to clarify, specify and organize their own internal requirements to meet the needs of abuse victims, their families and the offenders. This emphasis and its overall success will be greatly enhanced by the facility's commitment to fostering a comprehensive network of preventive, treatment and support services in the community characterized by mutual cooperation, coordination and support.

■ APPENDICES

I POLICIES AND PROCEDURES CHECKLIST FOR HEALTH CARE PROGRAMS RELATED TO ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE

NOTE: Specific policies, procedures and protocols should reflect provincial legislation, standards of care and the institution's philosophy and mission. The following elements should be included:

- Role of each professional group involved in providing services
- Documentation requirements
- Duty to report
- Informed consent procedures
- Obtaining and handling forensic evidence
- Basic elements to be included in assessment and intervention
- Abuse/assault team(s) or committee(s) where appropriate
- Available follow-up services and mode of mobilizing them
- Method of interfacing with other hospital-based and community services, and
- Confidentiality and release of client information.

II CHECKLIST FOR CARE AUDITS RELATED TO ABUSE, ASSAULT, NEGLECT AND FAMILY VIOLENCE PROGRAMS

Care audits might focus on:

Identification

- Are cases being missed or misdiagnosed?
- Are criteria for intervention being met?
- Are emergency measures being performed according to protocol?
- Are appropriate team members being notified in cases of suspected abuse?
- Are the police being contacted when appropriate?
- If death occurred, was the Coroner/Medical Examiner notified?

Assessment

- Does the medical history indicate past incidents?
- Are medical records being reviewed for details of past incidents?
- Is information obtained from persons who accompanied or referred the patient?
- Is the patient interviewed separately from (suspected) assailant?
- Are the victim's social support networks being assessed?
- Is the physical examination completed according to protocol?
- Is the victim's level of danger being assessed?
- Is the assessment completed according to protocol?

Intervention

- Are the immediate needs of the patient being addressed?
- Is a plan prepared?
- Are procedures explained to patient?
- Are counseling and specialized treatment/service relevant to the patient's needs?

- When indicated, are the appropriate child welfare agencies notified?

Referral/Follow-up

- Are viable referral mechanisms in place?
- Is a list of referral resources accessible to the institution's staff?
- Are referrals consistent with the client's identified needs?
- Do clients comply with referrals?
- When a case review is indicated, is it carried out?

Documentation

- Are appropriate forms being used?
- Is documentation appropriate re:

  - identification
  - assessment
  - intervention, and
  - follow-up/referral?

Outcome

Evaluation of the extent to which a program meets its overall objectives and goals will present complex challenges in this particular area, as in many others. Consideration of the perspective of the client or patient group in judging the success of abuse, assault, neglect and family violence programming provides valuable feedback for both ongoing program development and quality assurance. Such feedback from the perspective of the client/patient group can be built into the follow-up program in such a way that it strengthens the supportive intentions of the follow-up by facilitating the expression of both positive and negative feedback from the client.

III SUGGESTED ROLES FOR STAFF

Each facility should develop its own job descriptions to meet individual program needs. All types of staff will not be required in all programs. All disciplines should be involved in program planning, in the development of relevant policies and procedures, and in the preparation of relevant training programs. The tasks listed below relate to the intervention and management of abusive situations and are suggested roles only.

The Role of the Coordinator

This individual may represent any discipline and should monitor the abuse/assult program, ensuring that the program as established is running smoothly, correctly and efficiently in accordance with its mandate. The Coordinator would also:

- Perform the responsibilities delegated by the Chief Executive Officer of the Hospital
- Oversee that all disciplines work well together
- Determine which committee members/professionals need to be involved in any specific case
- Obtain representation from outside agencies when necessary
- Establish and maintain liaison with outside agencies including the police, protection services and the justice system
- Ensure that all members of the interdisciplinary team know their roles and the roles of other professionals, and that they follow them
- Gather information with regard to appropriate protocols, kits available, procedures, etc. and review them with committee members
- Make recommendations with respect to appropriate protocol design
- Ensure that patient information brochures, kits and protocols are kept up to date and in line with any provincial/federal legislation and medical developments

The Role of the Physician

- Take history and do physical examination
- Treat acute problems of injury, disease or pregnancy and document medical evidence
- Contribute to the diagnosis of abuse/assult
- Obtain forensic data for legal proceedings
- Make appropriate referrals regarding psychological effects of trauma and/or other conditions which may require specialist's assistance
- Initiate and/or contribute to the necessary follow-up process as appropriate

The Role of the Nurse

- Contribute to the assessment of the child or adult and/or assessment of the family dynamics
- Collect data from child or adult and/or family members, and document
- Provide treatment and support to the victim and/or family members
- Call individuals needed to provide acute care where appropriate to the situation and the settings, e.g. police, crisis intervenors, physician, abuse team coordinator
- Observe and document functioning of child or adult victim and/or family members for assistance in management plan
- Make appropriate referrals for follow-up
- Provide emotional, non-judgmental support to the victim
- Assist in examination of victim and collection of forensic specimens
- Provide victim with information/education regarding options/legal process, etc., and
- Ensure required assault kits are available in emergency department.

The Role of the Social Worker

- Interview child or adult and/or family members and complete family assessment where appropriate
- Contribute to the diagnosis of abuse/assult
- Assist in the communications process between family, medical staff and outside agencies
- Provide victim with information/education regarding options/legal process, etc.
- Provide treatment and support to child or adult victim and/or family members
- Obtain consultation from other team members as necessary, and
- Assist in follow-up referrals.

The Role of the Staff Educator

- Provide appropriate training for hospital personnel in abuse, assault, neglect and family violence
- Provide appropriate training to help hospital personnel in meeting the needs of victims presenting immediately after the assault/abuse, or those disclosing a past experience of assault/abuse
- Identify centres where staff can have extra training
- Make available for the health facility and staff resource materials such as books, journals, films, audio-video tapes, and appropriate equipment for the improvement of knowledge and skills in the area of abuse, assault, neglect and family violence
- Arrange "in service" conferences, speakers and workshops for health care personnel on abuse
- Address issues of staff stress or problems presented by staff unable to deal with abuse because of personal experiences, and
- Ensure staff is educated to understand how their own biases and past experiences may influence their ability to provide services to particular victims or offenders in cases of spousal abuse, sexual assault, elder abuse or child abuse victims or offenders.

The Role of the Crisis Intervenor

These individuals could be trained volunteers, social workers, or appropriate religious personnel, etc. They may be hospital or community based. Crisis intervenors are used particularly to provide support and service to victims of sexual assault, but they can be used effectively with other types of domestic violence, such as spousal abuse. They would be called to:

- Provide support to the victim.
- Provide victim with information/education regarding options, legal process, etc.
- Provide or refer for ongoing, follow-up counseling.
- Identify centres where staff can have extra training.

The Role of the Psychologist

- Contribute to the assessment of the child, adult or offender and/or assessment of the family dynamics
- Provide treatment and support to the child, adult or offender and/or the family
- Maintain liaison with other professionals and service providers for follow-up with respect to ongoing mental health needs of the child, adult or offender and/or family
- keep abreast of research findings in early identification and prevention, treatment and rehabilitation of victims and abusers.

IV LIST OF GUIDELINES FOR INSTITUTIONAL PROGRAMS

The following guidelines have been prepared by the federal-provincial Subcommittee on Institutional Program Guidelines. These guidelines were requested by the Federal-Provincial Advisory Committee on Institutional and Medical Care Services. Some of the guidelines are updated versions of those previously published by the Subcommittee.

Addiction Services in Hospitals (1984)
Adult Long-Term Institutional Care (1984)
Adult Psychiatric Services Provided by General Hospitals (1989)
Assessment and Placement for Adult Long-Term Care: A Single-entry Model (1988)
Breast Imaging Services: Mammography (1986)
Burn Unit (1985)
Cardiovascular Services in Hospitals (1986)
Child and Adolescent Psychiatric Services Provided by General Hospitals (1980)
Child and Adolescent Services in General Hospitals (1982)
Child and Youth Long Term Services (1985)
Computed Tomography (1986)
Day Surgery Unit (1982)
Dental Care Units in Hospitals (1979 under revision)
Diabetes Services (1989)
Diagnostic Imaging Services and Systems: An Overview (1986)
Diagnostic Ultrasound Facilities in Hospitals (1985)
Emergency Services in Hospitals (1989)
End-Stage Renal Disease Program (1986)
Geriatric Day Hospitals - Geriatric Unit in a Hospital (1979)
Health Care Related to Abuse, Assault, Neglect and Family Violence (1989)
Hospital Day Medicine (1984)
Intensive Care Unit (1986)
Magnetic Resonance Imaging (1986)
Nuclear Medicine in Hospitals (1985)
Organ and Tissue Donation Services in Hospitals (1986)
Palliative-Care Services (1989)
Patient Hostel Unit (1978)
Perinatal Intensive Care Units in a Perinatal Care Network (1986)
Pre-Hospital Emergency Services (1985)
Pulmonary Function Laboratories (1982)
Rehabilitation Medicine Program (1986)
Respiratory Therapy Service (1987)

Reuse of Disposables: An Information Report (1985)
Spinal Cord Injury Program (1986)
Stroke Program (1986)
Vital Organ Transplant Centres (1987)